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ABSTRACT

This book addresses the research and policy issues that emerge from the interface of different cultures as a consequence of migration. It includes articles on the following issues: (1) the contribution of the social sciences to an understanding of migrant health needs; (2) health care across cultural boundaries; (3) health care for labor immigrants; (4) philosophical considerations of health care policy and the position of ethnic minorities; (5) health care research and evaluation in a host country: The Netherlands; (6) health care and Moroccan and Turkish immigrants; (7) problems of health and health care research with particular reference to ethnic minorities; (8) health care research and evaluation from the country of origin: Turkey and Morocco; (9) social and health problems of migrant workers; (10) social and health care of Moroccan workers in Europe; (11) aspects of health care intervention in host countries; (12) advocating for migrants' health; (13) migrants' special needs in sexuality and family planning in Belgium and Germany; (14) health care and education aids for foreigners in the Netherlands; (15) mental health of migrants; and (16) psycho-social problems of migrants. The book concludes with recommendations for researchers and practitioners. (LHW)

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towards an understanding of the health care needs of ethnic minorities

Proceedings of a Consultative
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28–30 November 1983

Edited by
M. Colledge, H.A. van Geuns and P.-G. Svensson

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CONTENTS

Page

Acknowledgements v

Preface vii

Introduction — *M. Colledge & P.-G. Svensson* 1

Part I. The contribution of the social sciences to an understanding of migrant health needs — *M. Colledge & P.-G. Svensson* 5

Chapter I. Health care across cultural boundaries — *L. Sachs* 13

Chapter II. Health care for labour-immigrants: perceptions of problems — *I.P. Spruit* 32

Chapter III. Health care policy and the position of ethnic minorities; philosophical considerations — *G.A. de Jong* 76

Part II. Health care research and evaluation in a host country: the Netherlands — *M. Colledge & P.-G. Svensson* 89

Chapter IV. Health care and Moroccan and Turkish immigrants — *H.A. van Geuns* 92

Chapter V. The problems of research into health and health care, with particular reference to ethnic minorities — *H. Hoolboom* 103

Part III. Health care research and evaluation from the country of origin: Turkey and Morocco — *M. Colledge & P.-G. Svensson* 125

Chapter VI. Social and health problems of migrant workers — *Z. Oztek* 128

Chapter VII. Social and health care of Moroccan workers in Europe — *S. Nejmi* 138

Part IV. Aspects of health care intervention in host countries — *M. Colledge & P.-G. Svensson* 150

Chapter VIII. Advocating for migrants' health — *V. des Fontaines* 153

Chapter IX. Migrants and their special needs in relation to sexuality and family planning in Belgium — *F. Donnay & M. Dal* 158

Migrants and their special needs in relation to sexuality and family planning in the Federal Republic of Germany — *E. Thoss* 160

Chapter X. Health care and education aids for foreigners in the Netherlands — some examples — *M. Colledge, P.-G. Svensson & G. Broekx* 162

Chapter XI. Mental health of migrants — *M.P. Simoes* 172

Chapter XII. Psycho-social problems of migrants — *W. Alma* 187

Part V. Conclusions and recommendations — *M. Colledge & P.-G. Svensson* 196

Annex 1. List of contributors and participants at the World Health Organization meeting 201

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M.M. Colledge
P-G. Svensson

PREFACE

This book is based on the proceedings of a consultative group on ethnic minorities, jointly organised by the World Health Organization and the Netherlands government, who met in The Hague in November 1983. The conclusions reached at the meeting demonstrated the need for research policy to be redirected towards migrants' perceptions of their health, concentrating on language and cultural barriers rather than differences of race. This refocusing of research, the meeting concluded, would allow host countries the knowledge base to meet migrants' needs more efficiently within their existing health services, by better communication and understanding.

The authors of this book felt that the debate needed to be carried to a wider audience of researchers, health workers and educationalists. It is satisfying to note that the book deals not only with theoretical and methodological issues, but also attempts to address the practical consequences of health care intervention. I am confident that this volume will stimulate debate and discussion, which is essential if we wish to redress social inequalities and the vulnerable health status of migrants in several European countries.

Jo E. Asvall, M.D.
Regional Director

INTRODUCTION

M. Colledge and P.G. Svensson

The unequal distribution of health care is an important issue in the European region, and the organisation of health care services for vulnerable groups presents a major challenge for primary health care. In this context migrant populations in Europe merit analysis, so that outcomes for health care meet the need for health care as perceived by the migrants themselves. When engaging in a task of this kind, there is a great danger that the writer will be caught in the trap of generalisation and stereotyping. At the outset the authors wish to preface their remarks throughout the text of this book by noting that they share with others (1) the dangers of "ethnicity", which separates and differentiates by race, isolating groups and seeing their health as a problem of their racial characteristics, rather than problems of understanding when cultures meet, and that the main issue is that the hosts' health ideology seems to dominate the agenda. Research based on the former premises seem to have dominated work on race and health. Thus, it has generally looked at conditions which appear to affect particular ethnic groups, such as sickle cell anaemia among people of Afro-Caribbean descent and rickets amongst those of Asian descent or topics of special research interest to the medical practitioner, schizophrenia,leukaemia, and sexually transmitted diseases. (2)

As Donovan notes, at best, this type of research is insensitive and shows a failure to understand non-European cultures and their way of life. (3). Approaches which differentiate and separate rarely take into account social and environmental factors, and therefore are not able to develop the way different groups perceive social reality and inevitably produce results which are of marginal value in assessing health care. While it is necessary to take specific illness into account it is however important at a structural and historical level to assess the experiences of different ethnic groups within the European Region, because at this level real differences do exist which are pertinent to an understanding of the indigenous and host populations.

Fifteen million or so migrants are now living in western Europe meeting a growing demand for labour in the host countries over the last twenty years. They came northwards from the Mediterranean, Greece, Turkey, Spain, Portugal, Italy and Yugoslavia (4). In the United Kingdom there were two main waves of immigration. Firstly from the West Indies during the 1960's and then followed by immigrants from India and Pakistan.

The figure of fifteen million is only a very rough estimate, and does not show the full extent of the millions of men, women, and children who have come to countries for periods ranging from one year, a few months, or years. In fact nobody really knows how many workers and their families came, or how many are here now. As can be seen in Figure 1 showing the recruitment levels of migrant workers in Europe, the structural characteristics of different cultures can be seen in terms of the percentage of the population they make up.

The objective of this book is to address the research and policy issues that emerge from the interface of different cultures as a consequence of migration. It is sufficient to say that this has been not only under researched, but more important, in some instances badly researched. Also historically the implementation of health policy, however well intended, has been insensitive to the real needs of migrants. It is hoped that some of the arguments presented in this volume can redress the balance, and lay down a challenge to those who are engaged in research or policy to stand back and rethink the consequences of their policy and planning.

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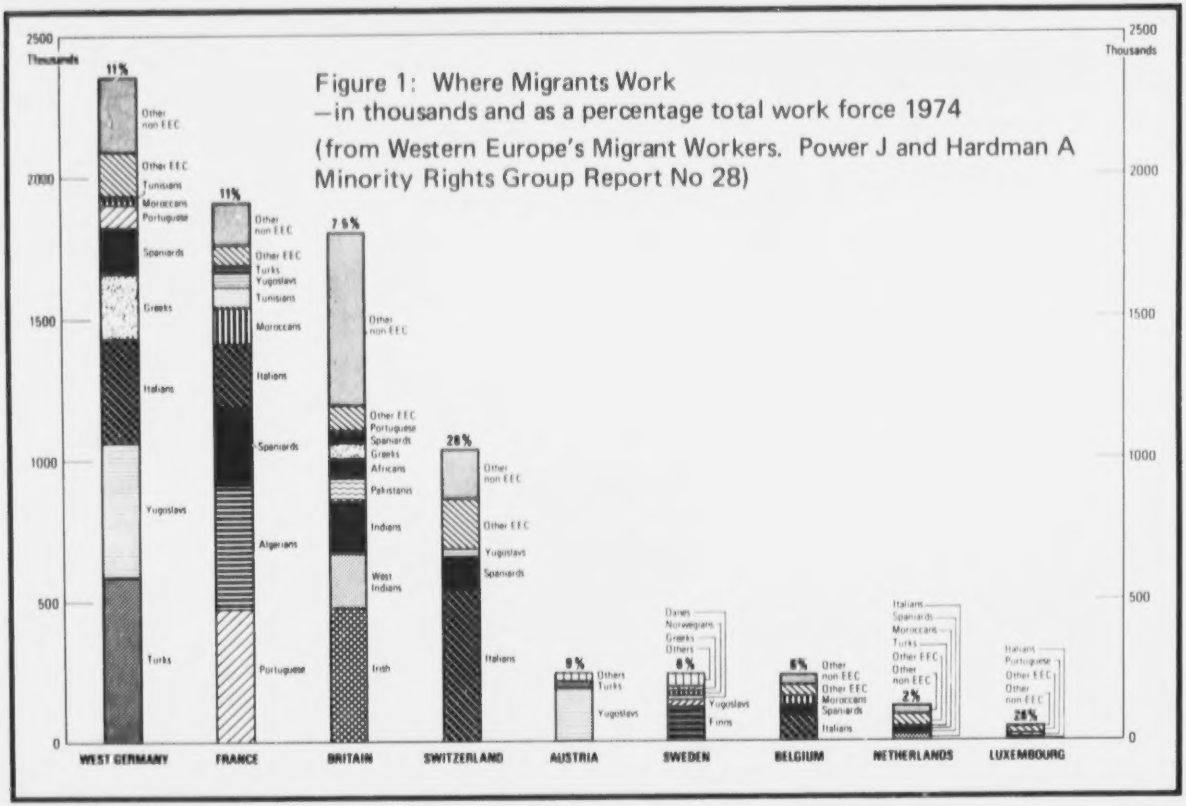

Figure 1: Where Migrants Work
—in thousands and as a percentage total work force 1974
(from Western Europe's Migrant Workers. Power J and Hardman A Minority Rights Group Report No 28)

PART I

THE CONTRIBUTION OF THE SOCIAL SCIENCES TO AN UNDERSTANDING OF MIGRANT HEALTH NEEDS

INTRODUCTION TO THE CONTRIBUTION OF THE SOCIAL SCIENCES

M. Colledge and P-G. Svensson

To set the stage for an approach to health policy and practice based on a clearer understanding of migrant health, we begin by looking at the sociological, anthropological and social policy analysis directed towards an understanding of the migrants, which is sensitive to their position, based on their constructions of social reality rather than the dominant ideology of the host nation. The reader will quickly realise that any attempt to discuss the health of migrants has been hampered by the lack of suitable statistics related to health and illness. Historically migrant statistics have been set within specific illness or infectious diseases, like tuberculosis, rather than in the broader characteristics of health and illness (1). Most of the data is spasmodic, uncoordinated, and has arisen from specialist medical interests rather than the health needs of immigrants. Evidence to date suggests that if we attempt to assess the epidemiological characteristics of ethnic groups, it will add very little to our health knowledge base. The measurement of mortality and morbidity rates of ethnic minorities is relatively easy to conduct but difficult to interpret. Firstly migrants may not be typical of the populations from which they come, being self-selective on the basis of physical fitness. Those who are able and prepared to uproot themselves and travel long distances to re-establish themselves and their families economically in another country, may not be typical healthwise of the population of origin. Statistical analysis is difficult, since we are dealing with minority groups, the number of deaths so far observed will be small and liable to sampling error. Finally other social indicators, rather than country of origin, but more specifically, social class position, length of residence, income and housing will lead to the migrant being exposed to the same health hazards and risks characterising the indigenous population.

Examination of Table I shows the untypicality of immigrant populations. The high value of standard mortality rates (SMR) of immigrants in Social Class One and Two are not significant, and the low values of Four and Five probably overstate the self-selection effect. According to Benjamin the SMR of immigrants rises with the length of time elapsed since entry, as they began to assimilate the dietary habits and other cultural and environmental factors of the host population (2). Effects of this assimilation effect have been shown elsewhere. Marmot et al. looking at ischaemic heart disease (IHD)in those emigrating from Japan to California found that mortality from IHD is much lower in Japan than the United States of America, but immigrants in the U.S.A. soon became subject to the higher mortality of the host country, and was noticeably greater among those who became culturally more "western minded".

Recent surveys in the United Kingdom have suggestd that West Indies and African black immigrants demonstrate different patterns of cardiovascular disease to those of Aisans. Adelstein draws attention to the high mortality from hypertension in people from both sexes both in the African commonwealth and West Indies. While for the Asians the rates are low.

The question that has to be asked about this approach to research is what does it tell us. Our opinion is very little; it fails in that although it attempts to explain the particular, it doesn't come to terms with the major health care needs of migrant populations. Also it is a clear example of "ethnicity", searching for differences, while ignoring the major issues. To facilitate better

Table 1: Mortality by country of birth and social class for males aged 15–64 in England and Wales. Standardised Mortality Ratios

Country of birth	Social class						
	I	II	IIIN	IIIM	IV	V	All males
India and Pakistan	122	129	114	105	93	73	98
West Indies	267	163	135	87	71	75	84
African New Commonwealth	177	147	116	93	101	170	121
Rest of New Commonwealth	133	108	113	94	111	79	102
Australia, New Zealand, Canada	85	105	108	104	88	89	99
USA	87	91	129	121	139	103	108
Europe (excluding UK and Eire	121	109	98	83	81	82	89
UK and Eire (excluding England and Wales	118	112	111	118	115	110	114
Rest of world (excluding England and Wales	139	128	122	90	89	76	100
England and Wales	97	99	99	99	100	100	100
All birth places	100	100	100	100	100	100	100

From *Variation of Mortality in the United Kingdom with Special Reference to Immigrants and Minority Groups* – Benjamin. B –in *Demography of Immigrants and Minority Groups in the United Kingdom*, edited by Coleman. D.A. Academic Press 1982 health and social services, target groups need to be identified by a mixture of qualitative and quantitative methods which can outline service and personal needs at a national and regional level. This will require an improvement of statistical services and the publication of vital statisics. Indepth studies and small area analyses could then be used to identify the characteristics and needs of ethnic populations. This section of the book will try to set the background to an understanding of how to redress the balance from "ethnicity" to looking at migration as an encounter between two populations, the host and the guest.

An example of research that meets the points outlined above is that of Sachs, who explored the experiences of Turkish women in Sweden in Chapter I which looks at health across cultural boundaries. Sachs sees the experiences of Turkish women in Sweden as an encounter between the Swedish system for health care and people from other communities. Viewed as a two-way encounter it is more relevant to consider **how** migrants use Swedish health care than to establish **whether** or to **what extent** they do so.

Sachs describes how for Turkish women the Swedish health care is only a part of their total health care framework. She attempts to explain how they see medical care within the context of their practices. They may draw on both folk medicine and scientific westernised practices. The sensitive approach of Sachs to the cultural perceptions of migrants based on their experiences provides data that can initiate a planning response that will meet real needs.

Spruit's chapter reinforces this perspective in her observations of doctor/patient interaction in the Netherlands against the background of how Moroccans see health and illness through a combination of the old ways from galenic humoral medicine, with illness seen as a consequence of not following religious laws juxaposed with seeking attention through western high technology medicine. Spruit goes on to discuss the consequences of this approach against the structural elements in health care, drawing attention to two important errors that can be made after discovering the importance of culture to illness and healing. Firstly, the danger is to relate all problems and incomprehensible behaviour to culture. Secondly, to gain a stereotyped image of culture which will lead to wrong assumptions about the possible background to illness. Accordingly it is suggested that the lack of basic research in health care has been fertile soil for other major misconceptions; a tendency to narrow culture to religion, mix up information about different cultures, assume for example, that all Moroccans are devoted Muslims; failure to discriminate between deviant and normally expected behaviour, e.g. women are not allowed to speak to male doctors and that Moroccan women have no rights.

Following Spruit's arguments it can be seen that at the level of both demographic data collection and ethnography that category mistakes can occur, that will impinge upon interpretation of findings and health care planning. The work of Sachs, and Spruit, alerts us to the fact that the researcher is dealing with sensitive data, which may be misinterpreted and also misused, so the researcher must always ask "What is this data being collected for, and why?" Minority groups are highly visible in a host society, and data may be misused for political purposes, either in health care, or more generally relating to immigration regulations.

Therefore it follows from the arguments presented that because of the danger of interpretation error, migrants themselves should have some say in the research agenda.

This could have the effect of not only a clearer understanding of ethnic minority needs, but also lead to a greater understanding between the two cultures. A cultural model rather than a disease model could have a direct effect on policy and planning, and could be the stimulus for a radical shift by government agencies to make suitable provision.

The health status of migrant workers and ethnic minorities is often seen by governments as problematic. Attention is focused on the special needs they may have, and the burdens they may incur for the state. To deny that they have special needs is to veer to an ideological position that offers no solutions, only rhetorical statements. De Jong in his chapter tackled the issue by suggesting that ethnic minorities deserve special attention in health policy, he then goes on to qualify his remarks by suggesting that their special needs are only to the extent to which their problems are greater than those of comparable majority groups. The main issue for de Jong is the removal of the language barrier, and accordingly the shift to western medical culture, by allowing migrants to gain competence in the use of the hosts' health care system. So removing the language barrier, which seems paramount in all chapters in this section, following from this it will lead to better access to services that meet their needs.

Any discussion of health care policy and migrants must of course be set within the perimeter of the overall ideological position of the country in general. So de Jong sets out his remarks against the **process** of distribution and the **outcomes.** His model moves from the libertarian position to equal access, arguing that policy for migrants should be seen within the latter.

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CHAPTER I HEALTH CARE ACROSS CULTURAL BOUNDARIES

Lisbeth Sachs

Introduction

In this chapter we shall be looking at the encounter between the Swedish system for health care and people from other communities. Many features in this account can be seen as general phenomena of meetings between institutions and individuals, whatever their cultural antecedents. It is important to bear in mind that the ideas and actions of an institution do not necessarily tally with what is customary in society in general. One should distinguish between things that happen inside established institutions and other social interactions.

The continuous interaction between members of our primary society and groups from other societies occurs on many different levels. At grassroots level - people in their daily life - the constant give and take inevitably produces changes in all concerned. This is where people form and reform, maintain or reject ideas, conceptions and knowledge, everything that is established in daily life through behaviour and actions. This is what I mean by culture; all the thoughts and ideas as well as all the products of our joint experience of life together, everything "inside us". It is with our culture that we meet other people and try to communicate with them, just as it is in this way that culture changes.

An institution like the health care system incorporates people with different cultures, i.e. they belong to different groups in the community. Inside the institution, however, interaction and communication proceed in a formalised manner that generates rules for how one should act and think. One could say that a separate culture is created in institutions such as those for sick care. This is a result, among other things, of the specialist knowledge that underlies routines there. Their foundation is biomedical and a set of roles is established for sick care. These roles do not change much but those who inhabit them do. Both the roles and the routines have become increasingly stereotyped and rather immutable as a result of demands for efficiency and management.

When talking about institutional health care and its encounter with patients from other societies it is necessary to include the critical debate and internal problems that the health care system encounters even without these particular patients. This makes for a fairer picture. Many immigrants from southern Europe, for instance, have come into contact with formal, biomedical health care before, but this has differed in many important respects from the system we have to offer.

Different people's experiences of western types of health care must be compared with the cultural product that is the Swedish system. Each country has its own way of practising biomedical health care, depending on the particular political and economic circumstances. Health care ideologies in different countries are in large measure a function of political, economic and social factors, as is the general health of the population.

But there is more to it than this. Some of those who migrate from developing countries to the Swedish welfare society feel that their health has suffered as a result. Perhaps they do not use Sweden's financial and social safety net in the way that we expect. The health of these people is not determined solely by circumstances, such as material conditions, which cannot be altered immediately. Health is also conditioned by factors that are part of a person's culture.

It is chiefly such factors that I shall consider here. To illustrate the general argument I shall draw on my experience from research among peasant women from Turkey and how they think and act in connection with illness in Sweden (a bibliography is given at the end of this chapter).

Different systems for health care

In order to gain some insight into the problems that are now being recognised concerning immigrants in health care, we must first consider what it is we offer people who have never met our particular form of health care before. In doing so we must start from what those people have been accustomed to encountering when they have felt a need for assistance with illness.

When people fall ill - have symptoms that they themselves find unpleasant - they want to do something about it, wherever they may happen to be. They look for an explanation for what is happening to them, preferably also some form of treatment to overcome the discomfort. What usually happens is that they, together with those in their immediate surroundings, try to identify the cause of the symptom. This we call a **personal** form of sick care, the form that is practised at home or that involves the individual, the family, relatives, friends and the informal network of non-specialists in general.

If no way of getting rid of the sick person's discomfort can be found in this personal sphere of sick care, assistance may be sought elsewhere. The steps actually taken will depend on what is available in the vicinity and whether it inspires confidence. In Sweden this may be a health centre, a district nurse or a doctor not far from home. For women in the Anatolian countryside it is the folk healer, magicians of various kinds and the doctors with a biomedical training at a small local hospital. One can say that between the personal sphere and the formal biomedical sick care system there is what we can call the **folk sector.** This exists in Sweden, too, but here it usually serves as an alternative to the biomedical system after this has been approached.

The folk form of sick care is generally closer to the personal sphere than is the biomedical system. The chief distinction between them in Sweden is that folk healers are not entitled to sick-list people, which is a way of legitimating illness as a socially accepted role, with all that this means for the patient, not least financially.

This brings us, finally, to the **biomedical** care, which is where one finds specialists with a scientific training and practice. These doctors may be part of a large, bureaucratic health care organisation or practise on their own. They may or may not have access to scientific apparatus and medicines. As mentioned earlier, this form of health care may be arranged entirely differently in other societies. In Turkey, for instance, the great majority of these doctors are in private practice. This means, among other things, that they prescribe medicines more generously, are not in a position to examine patients with the aid of advanced technical devices but have to rely on an entirely different type of diagnosis.

What this amounts to is that people in general can be assumed to have had access, in one way or another, to a health care system, a system that has functioned for them, providing the assistance that they are accustomed to, believe in and understand. The extent to which they have been aided by this health care is something that we are not in a position to judge, lacking as we do the necessary insights into the complex interaction between ecological adjustment, social relationships and ideas. What we can learn from is people's experiences, whether they feel that their accustomed sick care has helped them.

When I questioned the women from Anatolia about such matters they replied that they have always been helped by their folk and biomedical health care systems whenever they had occasion to venture outside their personal sector. The fact that they have this experience - even though, from a biomedical viewpoint, sickness and death are high among children in the district - has to do with our deeply-rooted need for explanations when our existence is threatened. We resort to the explanation that have been created in the environment in which we live, explanations that are an integral part of the culture we share with those around us. This is something that we all do as a matter of course. It is only when we distance ourselves from the environment in which our conception of reality has been formed that we are liable to reflect at all consciously on the nature of our explanations, usually because they are questioned in our new surroundings. More about this later. Here we can note that every community or group of people who live together, sharing the same environment and living conditions, has some form of health care. This may consist of various components, separated from each other to a greater or lesser degree and forming a whole that we can call a **health care system.**

When people with a different health care system seek the health care that is available in Sweden, the two sides may have difficulties in communicating. The reason for this may be, for instance, that they expect different things of the encounter. But this is just one aspect of the misunderstandings that may be involved in a cross-cultural sick care encounter. Another has to do with our conception of illness.

Illness as culture

The ideas and actions that are encompassed by a health care system are related to signals from our body. As cognitive, sensitive individuals we transmit these body signals - perceptions of pain, nausea, giddiness and so on - in a culturally prescribed manner to indicate that we are ill. These manifestations, however, are interpreted by those around us in accordance with their ideas and conceptions of the body and illness. Each one of us reacts in the light of personal experience and the individual lessons we have drawn from this. From this it follows that a particular individual has one set of ideas and conceptions about a particular illness, a folk healer has another set and a Swedish doctor a third.

When the women from Anatolia apply for treatment in Sweden in connection with illness, they do so having first established in some way that they are in fact ill. It is by no means certain that this opinion is shared by those around them or by the specialist they consult. To get at the reasons for this we can consider different aspects of the concept of illness.

In the Swedish language the same word, **sjukdom**, is used both for the discomfort, pain, nausea and so on as perceived by the individual and for the disorder as observed more objectively by, for instance, a doctor. Everyday usage in other languages is often similar. For our purposes, however, it is important to distinguish these aspects. So instead of talking in general terms about **sickness**, I shall use the distinction that medical anthropology makes between **illness** and **disease** (see Fabrega & Manning, 1974; Kienman & Eisenberg, 1978; Rubel, 1964; Fabrega, 1972).

Illness stands for whatever a person perceives as ill health. It is these individual experiences of discomfort that have to be communicated in such a way that the person in question is regarded by others as ill. The things that a Swedish doctor observes directly in encounters with patients whose language and means of expression he understands are manifestations of illness in this sense. Illness comprises expressions for the subjective perceptions (symptoms), not necessarily visible (pain), that are communicated, verbally or otherwise, in a culturally prescribed manner.

A doctor, however, may also discover things of which the patient is unaware (signs), e.g. such changes as fever, anaemia, high blood pressure, cellular changes and so on. He can do this even without understanding the patient's language or means of expression. He does not actually need the patient's active assistance. The signs are communicated in a different way. Disease accordingly stands for ill health arising from an "objectively" observable phenomenon that can be classified, explained and treated in biomedical terms.

Most people are acquainted with illness. We have felt ill and sought explanations and treatment for our ailment. But our ability to assess disease varies. We cannot investigate what is happening inside us. People in Sweden have some knowledge of how the body functions and what it looks like inside, insights that have been acquired in school and via the media. This is not necessarily common knowledge in all societies. So while we can assume that knowledge of illness is a universal phenomenon, the identity of an illness cannot be taken for granted.

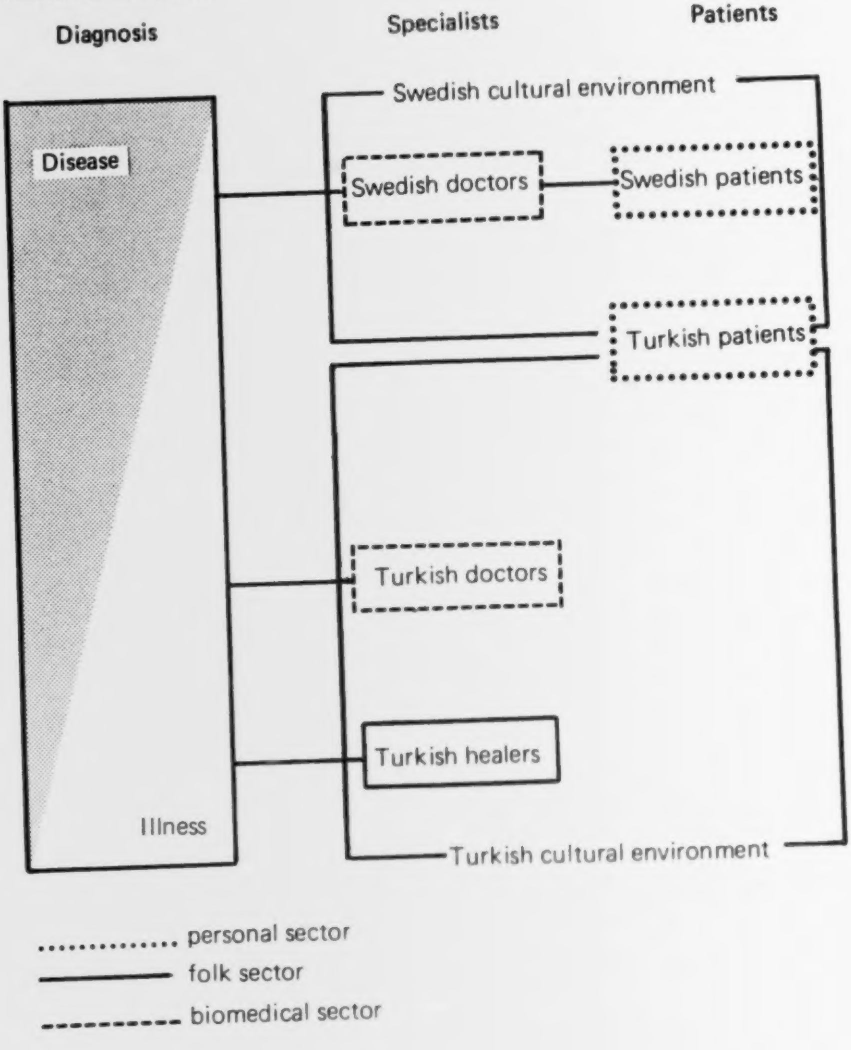
Illness is a function of ecology and environment, of social relationships and of rights and obligations in a particular community. Explanations for illness may also differ widely with the cultural setting. The ways in which we explain illness, misfortune and death are bound up with our ideas about our origins, life's purpose and the part played by external forces. Before considering differences in these respects, I shall discuss how our approach to a new form of health care is influenced by our past experience of a particular set-up.

The power of experience

To illustrate the subject of this section and bring home its point I shall introduce the specific case of the women from a farming community in Anatolia. As a further aid I shall be referring to a diagram (Figure 1) of a health care system and its three sectors: personal, folk and biomedical. In each of these sectors there are various persons who are of importance for the women in connection with illness. Different illness episodes acquire their particular significance from the extent to which the diagnosis and treatment match both the illness that the woman feels and wants help for and the disease that doctors with a biomedical training can discover and treat. As the diagram indicates, the Turkish patients exist in two socio-cultural environments simultaneously, whereas Swedish patients have just one. These Turkish patients differ in this respect not only from Swedes but also from immigrants whose ties with their earlier community have been severed more completely. The latter groups **may** have alternative forms of treatment available, such as folk healers, but this is irrelevant here. The Turkish patients have specialists in both environments - a biomedical sector in both but a folk sector only in the Turkish environment. The personal sector is located wherever the patient happens to be, before, during and after encounters with specialists.

The Turkish healers in the diagram stand for healers who employ both technical and magical forms of treatment as well as those who rely on magic alone. Technical

Fig 1
Health Care System


Diagnosis
Specialists
Patients
Swedish cultural environment
Disease
Swedish doctors
Swedish patients
Turkish patients
Turkish doctors
Turkish healers
Illness
Turkish cultural environment
personal sector
folk sector
biomedical sector

therapy here stands for direct intervention on the body, while magical therapy consists of actions performed outside the body (blowing on it, reading over it, attaching amulets to it and so on).

In the event of technical treatment (incisions, setting bones, cupping and so on) the patient is invariably accompanied by one or several relatives, who discuss causes and the prognosis with the healer. The interaction is characterised by candor, shared concepts, and a sick role and specialist role that the parties accept and understand. Symptoms are communicated by the ill person in much the same way as in the personal sector of his or her health care system. The symptoms are appraised against a shared view of reality, created in the Turkish environment that the healer and the patient share.

In magical treatment alone the interaction is not so explicit or verbal and the ill person may not necessarily speak for herself - she is not always present. A close relative may call on the magic healer and recount the symptoms presented by the ill person, whereupon the healer performs, at a distance, the ritual that symbolically drives the evil influence away. It follows that magical treatment can be performed in Anatolia on a person who is ill in Sweden. Written amulets from such consultations can be despatched with someone or posted to Sweden. Healers using technical methods, on the other hand, have to be consulted in person.

There are several reasons why this form of health care has survived to such an extent and even become more prevalent at times. One reason, discussed earlier, has to do with the health care encounter, in that expectations are largely based on a common frame of reference for diagnosis and treatment. Moreover, the healer role and the sick role are rooted in the same socio-cultural environment.

The Turkish patient meets a Swedish doctor under completely different circumstances. The encounter as such is fraught with conflicting expectations. The mutual problem has to do with the lack of a common frame of reference for diagnosis and treatment, combined with misunderstandings about each other's roles. The Turkish patient's conception of a physician - represented here by the Swedish doctor - has been constructed, not in the socio-cultural environment in which this encounter takes place but in Turkey. It is Turkish doctors there who have been her examples of how a scientifically trained medical specialist should function. The patient's way of expressing and describing an illness, her illness behaviour, is founded on what she can and is entitled to expect of a Turkish physician.

The way in which the Turkish patient appraises a health care encounter with a specialist of the kind represented by Turkish and, in our case, Swedish physicians is ultimately a consequence of economic and politcal conditions in Turkey. The private practitioners there whom these patients generally encounter do not have access to the advanced technical apparatus that would make it easy to confirm a suspicion of an internal pathological change.

What Turkish doctors are expected to do in the first place is alleviate symptoms. They prescribe medicine in the form of pills as well as injections. Their patients regard an injection as the most effective way of receiving biomedical treatment. The doctor knows, moreover, from his acquaintance with the patient's socio-cultural background that medicine will not be taken when the symptom has subsided; an injection of antibiotics, for instance, may therefore be more effective than a medical prescription. The doctor has an authoritarian attitude and commands respect; he wears a white coat, states his opinion on the case and does not convey an impression of uncertainty by asking questions that seem irrelevant. Women are not obliged to undress for an examination. The doctor assesses their condition without intricate examination and his role is primarily that of a technician.

Swedish doctors, unlike their Turkish colleagues, have to be sparing with medicine until the result of tests and examinations makes the diagnosis reliable. For this purpose they have access to advanced technical apparatus. If the pathology is obscure, they usually refrain from administering strong drugs. Patients from Turkey expect to get medicines that kill pain, promote sleep, revive their appetite and act as stimulants. All these kinds of medicine, as well as some type of antibiotic, may well be included in a single prescription from a private practitioner in Turkey.

The role of a doctor in Sweden is not the same as in Turkey. In Sweden it has been questioned and debated in recent years and the authoritarian aspect is less acceptable than it used to be. As a result, some young doctors have taken to under-communicating their authority, using symbols such as dress, speech and behaviour. They may take to wearing jeans, wooden clogs and a T-shirt, speak to patients as though they were good friends, pat their shoulder and try to create a relaxed atmosphere.

When the peasant women from Turkey turn to a Swedish doctor for the form of help they have been accustomed to getting from doctors in their native country, it is just such discrepancies as these that play such a vital part for the encounter as well as for the subsequent course of the illness episode.

The specialists in the two environments in which the Turkish patients exist are used by them in accordance with their symptoms. Thoughts and actions that rise from combinations of impressions from these two environments merge into what we can refer to as the socio-cultural system of these patients. It is this system that influences the way in which the Turkish women handle illness in Sweden.

When the women move between two communities that are as disparate environmentally and socio-culturally as their farming homeland in Turkey and a metropolitan suburb in Sweden, they have to confront many new questions. These include matters to do with the causes of illness and the effectiveness of treatment. The two environments also give rise to different symptoms among them and their children. As a result, the functions of specialists are questioned or sometimes reinforced.

In order to spell out something of the complexity that may be inherent in a trans-cultural health care situation, the time has come to touch briefly on the subjects I mentioned earlier: how people explain misfortunes, illness and death, and the way in which these explanations play an important part in the development and resolution of an illness episode.

How we explain the world

People in different communities have different explanations as to why we fall sick and die, why the rain destroys the harvest and why a house is destroyed by fire. In our philosophy or view of the world we usually have alternative ways of explaining ways of explaining events that occasion anxiety, disorder or threats. These alternatives are integrated in the system of ideas on which we fall back to cope with problems in daily life.

The Turkish peasant women have two types of causal explanations and these are not mutually exclusive. In this they are by no means alone; we, too, can recognise ourselves in the following.

When a child falls ill in the depth of winter or the height of summer, the women from Anatolia know that a force - the cold or the heat - has entered into the child and rendered it ill. At the same time, many children survive the winter and summer without falling ill from the cold and heat; neither are there children who fall ill every winter and summer. Accordingly, the woman also has to consider **why** the cold or heat has afflicted just her child at this particular time. The answer to this question - why something has happened that does not happen to everyone on every occasion - lies in the omnipresent forces that afflict people in a more arbitrary way. For the Turkish women these forces are God, evil spirits, magic acts by other people and the evil eye.

For the Turkish women the latter causes, which are part and parcel of their world of ideas, serve to link phenomena that are mutually independent. They have a logical explanatory function when matters that generally function smoothly happen to covary so that the natural order is upset.

In other words, when things happen that are disturbing or unfamiliar, the women from Turkey - like anyone else - seek an explanation. When a member of their group falls ill, they try to identify the cause of the illness. Their search is guided by the etiology, which also underpins their actions. An etiology invariably takes the form of a narrative, an account of what has happened. It is anchored in time, episodic and may refer to a period before the illness struck. As an explanation a woman may say that her child came under the influence of an evil eye on such and such an occasion, which is why it has been weak and ill ever since. When a Swedish doctor examines the child, his etiology tends to focus instead on the mother's responsibility - an inappropriate diet, failure to protect the child from infection or leaving it unattended. The two etiologies are poles apart on the subject of who or what is to blame. This is not unusual either - the etiologies offered by Swedish patients are also liable to differ from those constructed by a doctor.

Health care arranges and changes

The time has come to sum up these impressions from cross-cultural health care encounters. In doing so we must constantly bear in mind that such encounters involve a multitude of factors and phenomena concerning each one of the actors.

In the first place we have now seen that a health care system comprises a number of sectors. These can covary to provide an appropriate starting-point for the treatment of illness. No one lets a serious illness simply run its course. On the contrary, we draw on the alternatives that are available, individually and in our surroundings. This makes it more relevant to consider **how** immigrants use Swedish health care than to establish **whether** or **to what extent** they do so. Their total health care system may include Swedish health care as just a minor supplement and one, moreover, that they may use in very unorthodox ways.

It is also clear that the part played by the personal sector in such a system varies. The Turkish women referred to here have been accustomed to managing ordinary illnesses at home, relying entirely on personal care. The concept of self-care, which is being promoted at present in Sweden, is something they take for granted. In Sweden, however, this self-reliance confronts a welfare society, with public institutions for health check-ups and keeping an eye on how people manage their health.

Health care personnel from, for instance, the child health centre get in touch with every family that moves into a district. The women from Turkey were encouraged to bring their children to the centre, not least because the staff were unfamiliar with the way these children were being looked after. The staff felt uncertain that the women were doing the right things to ensure the health of their children in their new surroundings. They wanted to gain some form of control over what was happening in the Turkish immigrants' homes and arrange matters there into something more familiar.

This has generated a situation where the health service is now having to shoulder an unexpectedly heavy burden. The women from Anatolia, in the throes of the changes inherent in their new social situation, lost confidence in their ability to manage their traditional responsibilities. Older women to whom they could turn for advice and assistance were not available to the same extent as in Turkey. Each time something happened to a child, its mother was reminded of her responsibility for the health and well-being of the family, an attitude that contrasted with the women's more fatalistic outlook. Slowly but surely, the Turkish women began to frequent the waiting-rooms at out-patient centres and emergency clinics in their search for someone to shoulder the responsibility that their uncertainty prevented them from carrying.

Reinstating personal care as a self-evident function will not be easy. An eagerness to arrange the existence of the immigrant families so that it tallies better with an extremely high standard of health, hygiene and safety, has had the unintended effect of transforming what was largely a functional health care system for some of these families. Looking back, one wonders what might have happened if these women had been permitted to evolve their competence in health care as the foundation of a system that also included support from Swedish biomedical care. As things have turned out, the women who grow up in Sweden will lack this competence, with all its traditional implications. Its place will be taken by Swedish parental education.

Health care arranges and changes, inevitably. People in Sweden are being strongly encouraged at present to shoulder responsibility for their health and the management of illness. Personal care is desirable, a right and an obligation. We must learn to see the health care institution in the light of reactions that it invokes among immigrants. We must learn to see it as a cultural phenomenon, an institution that confronts and influences each person who approaches it.

I have tried to reveal some of the complex implications of health care across cultural boundaries. Another lesson that should be borne in mind is that as long as people strive for survival and health, they will always look for a cure that is effective for them. In this search, Swedish health care is always an active part of the health care system of immigrant groups. This can be both helpful and harmful in various ways for the adjustment of these people to their new situation in Sweden. Still it is really only they themselves who can arrive at the combinations that are appropriate to their particular situation.

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CHAPTER II HEALTH CARE FOR LABOUR-IMMIGRANTS: PERCEPTIONS OF PROBLEMS

I.P. Spruit

Introduction

Between 1950 and 1970 the Dutch government concluded contracts with the governments of Italy, Portugal, Turkey, Greece, Morocco, Yugoslavia and Tunisia, in order to allow foreign hired labourers to work in the Netherlands. In 1981 350,000 foreigners out of these countries were legally registered to live in the Netherlands. The largest categories are the Turks (138,000) and the Moroccans (83,000). The range of their stay in the Netherlands may differ from a few months to 10 or 20 years. At present this also includes women and children who are united with their families, since the recruitment of foreign labour has been stopped. Every legally recruited migrant has been medically examined in his own country, before being permitted to migrate. This examination was meant to test the worker's suitability for labour and to screen him on contagious diseases. Family members, (legally) joining the migrant in subsequent periods, were also medically examined. Many illegal migrants received condoned (and cost free) medical attention, depending on the individual doctor's views, especially when this was needed for vaccinations or contagious diseases. In view of the medical examinations and a well-established system of tuberculosis prevention and control, it was originally current opinion in Dutch health care that: "medical care for the migrants was sufficiently taken care for by government measures and would not give further problems" (1). Did it not concern mainly young, medically selected people, who came into a country where health care is perfectly organized, where the institutions are easy to reach and the medico-technical quality high? An eventual language barrier was neither given much attention because: "this need not impede objective diagnosis" (1). However late in the seventies, frequent and regular signals started to come from medical practice, reporting nearly unsolvable problems.

The present common opinion in medical care is that a) "the" foreign patient costs extra time and extra money, b) that he is referred too often and often unnecessarily from family doctor to specialist, from specialist to another specialist and from that specialist to psychiatry, and c) that in the end he is more difficult to cure than "the" Dutch patient.

In psychiatric care this opinion is even more strong than in somatic medical care, and it is considered to be quantitatively (as far as foreigners are concerned) a large problem.

Community mental health organisations complain that foreigners do not wish their type of help. They have very few foreign patients. Only the religiously based and well-baby clinics report a rather positive attitude of foreigners toward their type of care. However, to maintain this satisfaction they face efforts that have to be greater than their limited manpower allows.

This opinion is represented in a vast body of literature of 200-300 titles; essays of widely varying quality, reports on conferences and special issues in medical journals. Ninety-nine percent of this literature is about Turkish and Moroccan immigrants. Relatively few of these titles refer to scientific research (2). Many are reports of unsystematical observations in people's own practice and subjective reports of medical personnel. The main topics are: 1) descriptions by providers of care of problems in attending to patients 2) popular and pseudo-scientific elucidations on the existence of these problems 3) descriptions of (emergency) solutions for the most poignant problems. There is also some attention for problems that patients may experience in their search for care, but this attention is of relatively little significance. Most of these very few descriptions are given by foreign social workers.

Quantification of problems

It is difficult to quantify the experienced problems, since there is so little research, but a few small scale studies quantify some of the problems that health care personnel experience and underline the impressions that came out of practice. In Utrecht, a middlesize town where many imigrants live, Paes (3) found in 1974 that slightly over 58% of the family doctors experienced their relation to foreign patients to be problematic. A general practice in an old district can include patients of six or more nationalities, speaking just as many different languages. Physicians found their relation to Moroccan patients most problematic and second most that with Turkish patients. The two most frequently mentioned problems were: good doctor-patient contact is impossible and it is impossible to get a good patient history. Especially a differentiated patient history is considered up until now impossible to obtain.

In hospitals too, doctors generally report the same type of difficulties, but on problems experienced in hospitals there is no quantification at all. However, a large part of the patients are foreigners. In children's wards this is up to 1/3 of the patient-population (4). The problems described are most of all communication difficulties, which remain even if interpreters are used (5, 6), and the unmanipulability of psycho-social aspects of complaints (7, 8), which are thought to be of relatively greater importance than in Dutch patients.

In 1982 Spruit and Van der Kruijk (9) found that 30% of the pharmacists in varying practices and 38% of their assistants were said to experience problems regularly in contact with foreigners, but up to 70% of the pharmacists and 46% of their assistants thought that many foreigners cannot use prescribed medicines correctly. One example of seriously wrong medicine use is the oral intake (sometimes even including the packet) of externally to be taken ones.

Hoolboom (10) found in occupational health services that 47 out of 112 reported to experience problems in assisting foreign workers. He also found that of all ethnic categories Moroccans and Turks are considered to be most difficult to take adequate care of.

Van Groenestijn and Epker (11) remarkably found that among social security health personnel few people thought to have serious problems facing foreign clients. However, a closer look reveals that personnel usually consider it in the end possible to fulfill their task, but experience quite a lot of problems while trying to achieve their goal. The amount of juridical procedures against their decisions (mostly regarding sick-leave recognition or disability status) also counteracts this perception of problems. Compared to other health care personnel they appear the least self-critical in evaluating the results of their decisions (12, 13).

Medicine's perception of problems

In addition to the literature an analysis was made of questions and debate in medical conferences and postgraduate courses (14). This revealed a hidden assumption of an underlying, but rather clear and consistent perception of a vicious circle into which medical care arrived. This circle is described in Figure 1 1. The central process that is perceived to establish this circle, is that it is impossible to establish a good doctor-patient relationship because the foreign patient is so different that they don't understand each other. Besides the doctor is substantially unfamiliar with their cultures, because doctor and patient cannot communicate. These communication disturbances are not only considered to exist in the language-barrier, but also include mimicry, behaviour, perceptions, roles, attitudes and mutual expectations. In current health care opinion, these communication disturbances influence nearly all aspects of medical interventions, via indicative phases in the therapeutic process. Of all these phases, most attention goes to the patients' behaviour and the consequences this has for the attending doctor. This implicitely includes that predominantly "deviant" behaviour is described: types of behaviour that appear to differ from the average Dutch patient and that are difficult to understand, to accept and/or to handle in a conventional way of supplying care. Sometimes this deviation is qualitative (different way of responding to the doctor, different presentation of complaints, different expectations from the doctor), sometimes it appears to be merely quantitative (foreigners demand more, often "unneccessary", home visits, more often turn to alternative - non-recognised - systems of medicine, they more often call the doctor in his "free hours" for complaints that are not really urgent).

The patient's behaviour

Frequently mentioned deviant behaviour refers to:

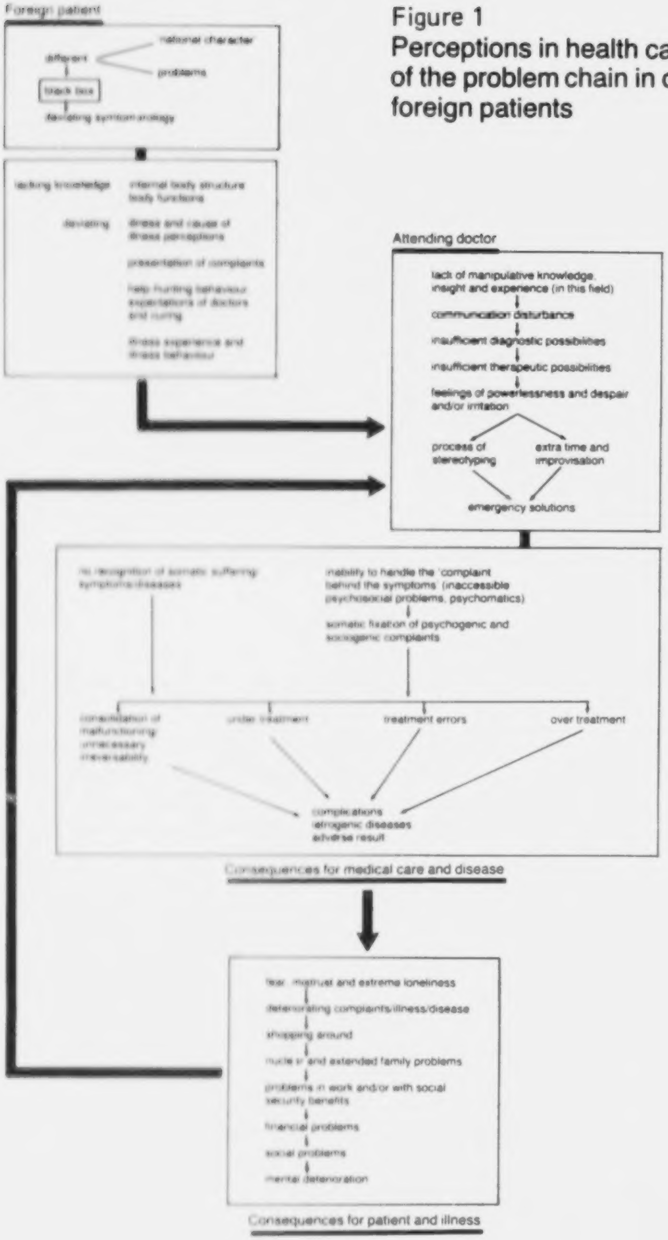
Foreign patient
different
national character
problems
black box
deviating symptomatology
lacking knowledge
internal body structure
body functions
deviating
illness and cause of
illness perceptions
presentation of complaints
help hunting behaviour
expectations of doctors
and curing
illness experience and
illness behaviour
Attending doctor
lack of manipulative knowledge,
insight and experience (in this field)
communication disturbance
insufficient diagnostic possibilities
insufficient therapeutic possibilities
feelings of powerlessness and despair
and/or irritation
process of
stereotyping
extra time and
improvisation
emergency solutions
no recognition of somatic suffering
symptoms/diseases
inability to handle the 'complaint
behind the symptoms' (inaccessible
psychosocial problems, psychomatics)
somatic fixation of psychogenic and
sociogenic complaints
consolidation of
malfunctioning
unnecessary
irreversability
under treatment
treatment errors
over treatment
complications
iatrogenic diseases
adverse result
Consequences for medical care and disease
fear, mistrust and extreme loneliness
deteriorating complaints/illness/disease
shopping around
nuclear and extended family problems
problems in work and/or with social
security benefits
financial problems
social problems
mental deterioration
Consequences for patient and illness

Figure 1
Perceptions in health care
of the problem chain in caring for
foreign patients

- deviant care-seeking behaviour and the expectations on doctors and curing. Behaviour that indeed influences the therapeutic process considerably is: a) the tendency to consult several doctors for the very same complaints ("they want their diagnosis to be checked", many family doctors conclude), b) shopping around when relief is not quickly attained, and c) the use of divergent medicines prescribed by many doctors (this may very well include medicines that do not go together and medicines out of other European or their own country, that are unknown or considered noxious). It is frequently stated that foreigners tend to repeat their appeal for help to the same doctor for the very same complaint too often and too quick, but it is also noted that calls for help come (too) late. Unanimous is the opinion that foreign patients want "instant" cure with very heavy medicines, preferably injections, and that they expect the doctor to be "omnipotent". A therapy that does not give immediate relief inserts nearly always non-compliance. Rather unanimous also, is the opinion that the patients mistrust their doctors. There are also many very detailed descriptions of behaviour that disrupts the doctor's daily routine. These are remarks on matters like the telephonic arrangement of consultation, calls for help at late hours or in weekend, etc. This behaviour indirectly may influence the therapeutic process, because it (generally negatively) influences the doctor-patient relationship.

- deviant presentation of complaints. Doctors often feel that foreigners do not explain themselves straightforward, but use an incomprehensible symbolic language. This makes it difficult to interpret their complaints in terms of diseases and on top of that their feelings of shame and their taboos lead them to reject necessary diagnostic and therapeutic techniques. This refers to examination of body parts that are taboo and to the use of some medicines, but it also refers to a clear verbalisation of feelings or life events that are felt to be negative, e.g. decrease of potency, family conflicts, being attacked in honour and prestige by behaviour of family or by gossip, or situations in which one failed to fulfill one's role prescriptions. Their experience of pain is considered to be different too (they cannot localise their pain, nor their complaints). In addition it is quite current opinion that Moroccans exaggerate pain, but some people firmly state that they undergo heavy pain so stoically, that acute pain-syndromes are often not recognised.

Beliefs and attitudes

However, not only deviant behaviour influences the therapeutic process. Attitudes and beliefs towards health and illness influence the doctor's success in explanations to patients on causes of complaints and the choice of therapy as well as the patient's illness-career. Frequently mentioned deviant attitudes and beliefs are:

- lack of knowledge of the body and bodily functions. Most statements are that foreigners do not have "any" (read: western/biological) image of things not visible at the outside of the body, neither of its functions.

- "strange" illness and cause-of-illness perceptions. Most bothersome appears to be that foreign patients cannot handle the soma-psyche distinction, that they do not recognise psychosocial causes of disease and that they do not accept responsibility for their own life-situation, illness and healing. These patients are generally considered to be rather non-compliant. The supposed lack of the psycho-soma distinction and of acceptance of psychosocial origins of disease is even considered **the** most important present problem in dealing with immigrant patients.

- "exaggerated" illness-experience and illness-behaviour. It is generally stated that Moroccan and Turkish patients behave too dependent, are immoderately afraid to be ill, and cannot be motivated to return to work when they have complaints that do **not** cause disability to work ("when a migrant receives medicines he immediately thinks he cannot work"). In general they are often considered to react "strange" toward illness, often with an underlying suggestion that many of them are malingerers or at least exaggerate their condition.

Deviant symptomatology

Not only the patients' beliefs, attitudes and behaviour make them more difficult to cure, there is also a rather firm conviction that their illness-pattern is different. Foreign patients constitute a relatively large percentage of the patients in hospitals (compared to their numbers in the Dutch population in general). In family practices they also consume a relatively large part of the doctor's time. The reason may be twofold: a) their health status is poorer, b) it is more difficult to cure them, so they remain longer in the care system and more physicians per patient are engaged in their cure.

There are a few indications that the health status of foreign infants and toddlers is somewhat poorer than that of Dutch children (15, 16). However, besides these few research results there are no figures on morbidity, mortality or iatrogenic diseases.

A current analytical starting point in medicine, is the patient's behaviour from the moment that he contacts the doctor. Little attention is being paid to factors influencing the immigrants health status and the decision to consult the doctor.

Nevertheless, the impression out of practice is not that the foreigners health status is poorer, but that the therapeutic process costs more time and more doctors. The reason is that their symptomatology is considered to be deviant. This symptomatology is vaguely described as: "more psycho-somatics". The reason for this poor observation appears to be twofold. 1) The opinion on psycho-somatic complaints among immigrants is not founded on observations of well-described symptoms, but on the current medico-reductionistic practice to conclude their existence when demonstrable somatic disorders are excluded. 2) Doctors find it difficult to interpret their patient's vague complaints, even if they have some knowledge of his/her cultural background. They often cannot estimate which parts of the patient story are medically important, what the roots are, which reality goes behind what symbolic language, etc.

Out of the life-event literature and literature on social change, we may assume that the observations on the importance of psycho-social factors of illness theoretically make sense. There are also a few anthropological studies on psycho-social processes that influence the health status of Moroccan immigrants. Failure in important culture-bound roles in the Moroccan kinship system can lead to serious health problems among a rather high percentage of the immigrants (17). This includes failure as a member of the extended family, e.g. toward family members remaining behind in Morocco in poverty, and failure as a member of the nuclear family. There are also more "conventional" variables known to influence health, which can be applied to foreigners. These are common material circumstances like bad housing, dangerous-, heavy- and overwork, financial problems, and immaterial factors like uprooting, identity loss, homesickness, belonging to the underclass. Health and food habits, disease and health history (unemployment, poverty, child labour, juvenile undernourishment), personality (18) and genetic factors (preferences for marriages with close kin) also influence people's health. However, they do not specifically lead to psychosomatic complaints.

Dorrenboom (19) describes a dramatic example in which nearly all difficulties of medical care are concentrated in one single case.

> Phase 1: April 1978 family-doctor D. received a 44-years old Turkish patient, an unskilled worker. On the patient's request he was taken over by doctor D, because he was dissatisfied with his former family doctor. Complaints: headaches, vomiting, stomach-pain. Therapy: medicines.
>
> Phase 2: One week later the patient returned with new complaints: headache, low back pain, dizzy spells, falling about. No stomach complaints. Hardly any somatic findings. Language barrier.

Phase 3: The patient's sick-leave appeared to be considered unjustified, because of which he legally protested. Doctor D. found out because the court's expert asked for information. There were vague complaints again and the patient was afraid to die. The consulted specialist neither found a sufficient somatic disfunction. One month later doctor D. was informed that the patient appealed against the court's decision. Meanwhile physiotherapy had been prescribed, but the patient did not show up.

Phase 4: June 1978. The patient was bitten by a dog. At first aid he showed a telegram in which he was urgently requested to return to Turkey.

Phase 5: Half a year later the patient came again to see doctor D. and showed him the Turkish medicines he got. He appeared to have problems over a woman who could not have children. No further explanation on this. In the next six months he visited the doctor three times, presenting differing vague complaints, but he did not show-up again for physiotherapy. He wished to be X-rayed, but the photo showed not too serious a disorder. The patient got medicines, but one day later returned to tell that they did not help. It became evident that he had too heavy work, but he again did not show up for physio-therapy (three times prescribed, without any result).

Phase 6: It was 1979 then. In the next half year the patient was X-rayed two more times and saw the doctor quite regularly. There was another conflict over his sick-leave; social security health care considered him to be a malingerer. Again physiotherapy was prescribed, the patient did not comply. His firm threatened to fire him and his lawyer wanted detailed medical information from doctor D. and another specialist examination. Doctor D. suspected a new aggravation of complaints on physical examination. It now turned out that the employer did not allow the patient to go for physiotherapy because this would imply sick-leave. The patient refused medication and walked out on Doctor D. because he refused to refer him to the hospital again.

Phase 7: After four months the patient returned with X-ray photos from Turkey. He told that they showed that he was seriously ill, but the X-rays showed the same minor disorders as the Dutch ones. Another half year of frequent consultation, X-rays and persisting complaints followed. There were two more conflicts over his sick leave.

Phase 8: It was 1980. The complaints still persisted. Doctor D. finally found a way to show (by drawing his position) his patient that he had no power over the judge in the next conflict over the patient's sick-leave, and that the doctor was only a witness who could be consulted. The doctor "told" him that he expected him to lose his legal proceedings, but that he had a good chance that his minor back-disorders would cause a recognised degree of work-disability in a few years. But the patient now had stomach complaints. At another specialist consultation in the hospital the patient refused to undergo the physical examinations and the trial ended in a fight. Doctor D. "gave up".

Discussion on medicine's perception of the problems

Observations and reality

In terms of social science, observations in health care are lay observations. It can be suspected that there was observation bias and it is not certain either whether the immigrants' behaviour and their words were well-interpreted.

Besides, such focus on the problem-side may suggest that successful coping and adaptation hardly exist, just like satisfactory doctor-patient contact and successful healing. However, medical care and social work are "problem offices" and people without health - or other complaints do not come to see them.

Since observation bias cannot be excluded and quantification of observations does not exist, it is uncertain whether there really is so much "deviant symptomatology" as medical personnel suppose. There is considerable disagreement in medical care on the definition of psychosomatic and psychosocial complaints. It is not even known what its prevalence is among native Dutch patients, so neither what its prevalence is among immigrants. The same applies to "deviant help-seeking behaviour". Among Dutch patients there are dissatisfied people too, looking for alternative ways of treatment.

However, it would 1) be wrong to underestimate the signalling value of these observations and 2) since the observations do give a very good impression of the way in which health care personnel experience problems, they constitute the framework within which the patients' complaints are being interpreted in health care. In these terms it is an important social reality, setting the frame of reference of medical acts. The nature of many complaints and the way in which patients present them, as well as divergent attitudes, beliefs and stereotypes of patients and doctors, hinder the diagnostic process. This in turn brings about illness-stimulating processes like the ones described in Scheme 1 (somatic fixation of psychogenic or sociogenic complaints; "psychologisation" of somatic complaints). The effect may be that efficacious treatment begins (too) late, impeded by irreversible complaints or iatrogenic diseases, not to mention the human misery in the family, the rising costs of medical care and the increased feelings of uncertainty and impotence among doctors as well as patients.

Analytical one sidedness

There is a clearly recognisable tendency in medicine to ascribe most of the problems in health care delivery to the immigrants' culture, their "deviant" behaviour.

However, Foster (20) noted years ago that even though local or ethnic disease theories change very slowly, the pragmatic and essentially empirical attitude of many persons enables them to rapidly alter or accept certain medical practices or behaviour. People are practical to a great degree. If, with their own eyes, they can see results that they recognise as beneficial to them, then regardless of their understanding of the reason, and notwithstanding traditions and belief, many persons will add to the old by accepting the new. Greenwood (21) explicitly describes Moroccans as people who in their own (native) health care system: "are pragmatists, a hypothesis is validated by a cure". Young writes: "... tradition focussed explanations tend to place the responsibility ... with the people and their way of life, rather than with the providers of health care ... The major empirical finding is ... that traditional medical beliefs and practices do not represent a primary barrier to the use of a physician's treatment ..." (22).

Medicine's perception of the problem cycle (Figure 1) is essentially only a providers' view on delivering care to foreign patients, despite its focus on communication/ interaction processes. From a recipient's point of view the problem cycle has to include health care factors too (23). This is shown in Figure 2.

Patient's perceptions of problems

Quantification

On problems of patients even less research is done than on problems of medical personnel. In the province of North Holland a small research project (24) showed some feelings of foreigners about their health (Table 1), and the percentage of people who experienced difficulties (language and other) in contact with the doctor (Table 2).

The immigrants' view on their health problems is mainly presented by social workers of their own nationality, many of whom feel overwhelmed by rather unsolvable problems. "As a Moroccan social worker I feel like being a waste-basket. Medical personnel deposit in me the hopeless cases that they cannot handle. I am far less educated, but because I am a Moroccan I am expected to bring the solution" (25). Foreign patients feel that their complaints are not understood or not even taken serious, that they are treated very distant and impersonal, that they are often sent back to work despite being ill and are afraid that their condition worsens because the doctors do not understand them. Many idealise their fatherland and in the Netherlands they feel lonely, deceived and in despair.

Figure 2 Factors influencing medical care for immigrants

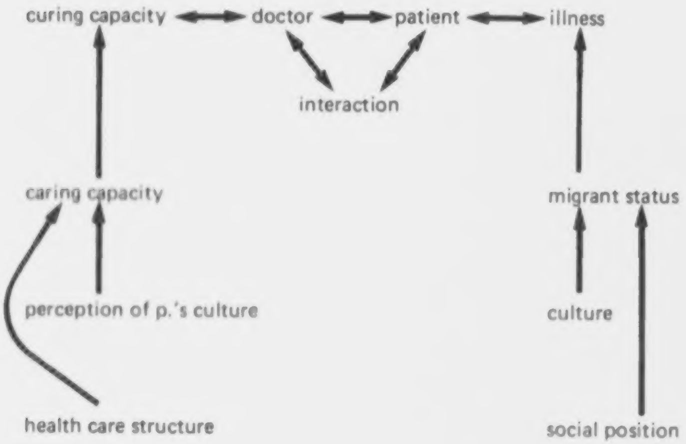
curing capacity
doctor
patient
illness
interaction
caring capacity
migrant status
perception of p.'s culture
culture
health care structure
social position

Table 1: Opinions of people on their health status (percentages)

	health was better in fatherland	health is better in Netherlands	health in the same	total
Moroccans	53	3	44	100
Turks	50	3	47	100
Yugoslavians	38	2	60	100
Italians	35	10	55	100
Spaniards	28	8	64	100
Portuguese	27	13	60	100
Total	40	6	54	100

Source: Regional North Holland Committee on foreign employees (24)

Table 2: Percentage of people who experienced (language and other) difficulties in contact with physicians

	with occupational physician	with social security personnel (control sick-leave)	family doctor specialist
Moroccans	34	40	45
Turks	35	35	30
Yugoslavians	9	**	2
Italians	10	11	8
Spaniards	10	10	19
Portuguese	29	21	26
Total	22 (N=139)	22 (N=138)	24 (N=150)

Source: Regional North Holland Committee on foreign employees (24)

** The control-system works slightly different for the Yugoslavians, due to supervisory arrangements of their government

Types of problems

A Moroccan social worker (26) described a case, that from the patients' view may resemble in several aspects the one described by Dorrenboom from the family doctor's view. (However, this case is a different patient).

Phase 1: Jilali has lived in the Netherlands since 1965, he engaged in heavy physical labour. His wife and nine children live in Morocco. He falls seriously ill in 1977, the first time since arriving in the Netherlands.

Phase 2: Neither family doctor nor specialist find any sign of a disease. After two months of sick leave he is summoned to go back to work.

Phase 3: Jilali's complaints persist. He suffers from pain in the chest and palpitations. He is afraid. He stays home again and gets fired. He legally protests against his rejection of sick leave benefits, but loses.

Phase 4: Jilali goes to Belgium, where the doctors find a heart disorder. He goes back to his Dutch doctor with the X-ray photos. They do not recognise his disease. It is 1978 now.

Phase 5: Jilali has been warned in Belgium for the serious consequences of his disease and he leaves for Morocco to get treatment. He loses his social security/unemployment benefits. He legally objects, objections not recognised.

Phase 6: Jilali has to sell his house in Morocco to pay for treatment. The Moroccan doctors consider him to be seriously ill, but he does not recover before he runs out of money. He returns to the

Netherlands and gets the lowest welfare benefits, by which he cannot support his family. He borrows more money. The doctors do not recognise the Moroccan diagnosis. It is 1979 now.

Phase 7: Jilali feels he failed everyone, he lost his honour and prestige, his family disrespects him, he has serious financial and health troubles, he also believes his body fails him. He can only regain his health when at least one Dutch authority recognises his illness. He collapses mentally and again goes to see the doctor. He is sent to a psychiatrist, who cannot find abnormal mental functioning (considering his difficulties). The psychiatrist sends him to another specialist.

Phase 8: In 1980 Jilali ends up in a Dutch hospital with a serious heart disease, mentally broken.

Not all cases end in an obvious somatic disease. Some remain under psychiatric care, others are lost out of sight by medical care.

Origins of problems: a balanced view

The patients' cultures

Educational courses and conferences on immigrant patients usually contain information on their cultures, the health care system and medical practices in their native countries. Such knowledge can certainly help to understand the problems and potential conflicts that may arise when they have to depend upon medical care in the new country.

Turks as well as Moroccans, for example, have a pluralistic medical system in which one and the same disease can have several causes (21, 27). The sick person has to choose out of a variety of healers the one that he hypothesises to possess the right skills to attack the origin of his disease. If the patient does not get well, one reason may be that he had a wrong hypothesis about the cause of his disease, so he will consult another healer. This belief-system may partly explain the tendency for medical shopping. There are several customs, like the preference for "strong" medicines, injections and X-rays and the expectations of immediate relief, which can be understood retrospectively out of culture and acculturational processes that took place when western medicine was introduced. The important magico-religious significance of words (28), the non-use of verbalisation of intimate feelings (29), the central values of honour and shame (30) may explain difficulties to discuss psycho-social aspects of illness. In traditional North-African and Turkish medicine such matters are not discussed, but redress of problems is offered by symbolic acts.

Many more examples can, and have been given. But there are also observations that do not seem to make sense, like the resistance to having blood samples taken, while "letting blood" is a common practice in several countries, or like the immigrants' denial of non-somatic origins of disease.

Illness, culture and healing are strongly interwoven. Without understanding culture, many illnesses are incurable. (31, 32). However, culture does not explain everything and retrospective explanations are not always valid, although they may appear to make sense. In acculturational situations the impact and meaning of many original cultural values, beliefs and customs change. Besides, not all immigrants come from countries where an elaborate system of indigenous medicine prevails. Dossen (33) showed that lack of confidence in Dutch medical care existed in 60% of a sample of Yugoslavian patients with somatic or psychological complaints. Dutch medical personnel assume this attitude to exist in such quantity in Turks and Moroccans only. This may very probably be due to observation bias, influenced by the quantity of Turkish and Moroccan patients and to failure to discriminate between various ethnic categories. It may also be, like Fernandez (34) assumes, that part of this attitude is inherent to the "condition migrante" (migrant status). Based on data out of his psychiatric practice, Kabela (18) believes that Spanish (im)migrants who develop psychiatric symptoms were already vulnerable before migrating since many of them had complaints when still at home, but this is not a finding that is generally confirmed in the literature (35-38) on migration and mental health.

Structural elements in health care

A few authors discuss the medico-technical cure-centeredness of western medicine, that leads to behavioural attitudes that make it ill-suited to deal with patients who are not socialised in the western medical belief system. Schillemans (39) hypothesised that this is the origin of somatic fixation of complaints, namely: a) the absence of manipulative knowledge and of the capacity to intervene outside a somatic frame of reference, b) the inability to positively handle (existing models of) latent doctor-patient conflicts (40, 41), c) the idea that all the patients' requests for help or problems need a solution from the doctor, and d) the idea that useless examinations (e.g. examinations to check his uncertain diagnosis, examinations to reassure the patient, elaborate examinations in order to exclude somatics in psychosocial problems) are not harmful to the patient.

To illustrate how other structural factors influence the output of medical care, serves a description of the geriatrist Sipsma (42), in which the words elderly or older are replaced by the words immigrant or foreign:

> "The unequal position of the (immigrated) person in health care can be illustrated by many everyday examples. Public health personnel and family doctors have insufficient knowledge of the (immigrants) problems. Besides, the (foreign) patient asks much of the family doctor's time ... Medicine prescriptions, the ways to take medicines and the ways to supply medicines do not take the (immigrants) into account ... Specialists do not have sufficient time for the slower reacting (foreigner) ... The ... functional structure of hospitals is not functional for (immigrants). This applies to polyclinics of general hospitals too. It is all too complicated and it goes too quick ... Referral possibilities do not exist sufficiently or are not being used."

The existence of such structural deficiencies in taking care of "non-average" people is certainly not a typical Dutch problem. It is inherent to western medical care and can be found in varying intensity in many western countries.

Management of problems

A disturbed equilibrium between cure and care negatively influences the system's alternatives to cope with new, unknown problems. Its poor capacity to handle psycho-social information and the "second rate" position of this capacity in therapeutic acts, often lead to stereotyping or simply not listening carefully to the patient and to a poor result in problem solving. On top of that many (psycho-social and/or cultural) factors influencing the foreign patients' health status and the healing process, are difficult to manipulate in medical care, for instance because it is out of its scope to influence social circumstances to a large extent. Only if it concerns individually changeable circumstances, caring medical care can intervene to a small extent. However, even then medical intervention seems failure prone. Two interrelated factors appear to influence this. Western assistance (especially for psycho-social problems) accommodates the individual. However, many foreigners come from cultures in which people are socialised to accommodate the group. This refers mostly to people who grew up in rural areas where life is organisationally, structurally and emotionally directed toward the group. Second, the smallest organisational social unit is the family, and medicine is familiar with delivering family health care. However, in attending to the family medical assistance is confronted with a very different, patriarchally coloured, family pattern. This holds most of all for Turks and Moroccans. This impedes efficient help to men, but even more to women and children, as soon as values, norms, attitudes or behaviour are included in the advice on problems, conflicts or diseases. In cases with a strong ethical component in medical advice, (e.g. abortions, sterilisations, consequences of maltreatment and violence), decisions have to be taken that are almost impossible to accept either by the doctor or by the patient.

Sometimes some of such problems may be solved by asking the assistance of religious or traditional healing if the doctor feels that he can accept such an intervention. Venneman (43) describes a situation in which this is successful.

> Mrs. M. was a 36-year old Moroccan with five healthy children out of eight pregnancies. In the

> sixth month of her ninth pregnancy she became mentally disturbed. She neglected her children and household, walked day and night through the house in heavy unrest and beat herself. The baby was stillborn and that was the first moment the husband consulted a doctor. The family was very upset and considered this stillbirth to be Allah's punishment for the wife's behaviour, since she was tormented by evil spirits. The doctor found out that these spirits made her not want the baby, since she was very tired of all the pregnancies. But children are a blessing of Allah, so this was very wrong. Therefore she beat herself. Despite all the doctors' efforts (including injections) her emotional state deteriorated severely. A psychiatrist came to help, but had to return too without success. Finally her husband decided to consult a Moroccan religious healer. When he came, his presence alone appeared to chase away most of the family's anxiety. The ritual took nearly two hours. At the end of the first session the woman's body relaxed and she slept quietly. After three sessions it was as though she was reborn and could function like before.

However, the two impeding factors, emerging out of the family structure and group-like socialisation mentioned above, are not equally applicable to all (im)migrant categories and traditional medicine is not so important in all of them, while the powerlessness to handle psycho-social aspects seems to refer to most of them. An important third factor is social change and acculturation. Social change and acculturation processes may affect norms and values to an extent that every decision works out wrong, because there is not yet a social structure to implement alternative or existing models that would diminish a person's stress or the conflicting demands on him or her. Sieval (44) describes this in the case of a Turkish woman who did not want an abortion, while her father demanded that she had one. If the woman would not obey her father she would be repudiated and not able to maintain herself mentally, socially and economically; if she would obey her father her fragile new feelings of her own developing identity would be damaged. Acculturation not only implies new problems in the new country, but also in the country of origin where people respond to social change (45, 46). In acculturational situations traditional medicine may face as much difficulties as western medicine, either because the type of problem is unfamiliar so there is no healing tradition at hand, or because the social environment is not as functional in symbolic healing as it was before, or is even absent where traditional patterns are uprooted. In acculturational situations, knowledge of cultural roots can help us to understand problems, but for solving them new models will have to be invented.

Psychosomatic complaints, culture and medicine

The avoidance of somatic fixation of psycho-social complaints has current high priority in medicine, although this approach is rather difficult to implement in medical care. This medical priority to avoid somatisation is in line with the supposed prevalence of "more psychosomatics" in the immigrants' illness patterns. However, it is not in line with the immigrants' perception of the problems in health care (47). Moroccan social workers emphasise rather the opposite: undertreatment and psychologisation or "culturalisation" of somatic complaints. With "culturalisation" two important errors are meant, that can be made after "discovering" the importance of culture in illness and healing: a) to relate **all** problems and incomprehensible behaviour to culture, b) to gain a stereotypic image of culture which leads to wrong assumptions about the possible background of complaints. In Dutch health care four other misconceptions strengthen the effect of these errors. Misconceptions that may be influenced by the lack of basic research, by the lack of knowledge of the international literature on this subject and failure of cooperation between medicine and anthropology to an extent that knowledge can be implemented in medical care. Such misconceptions are:

(1) narrowing the meaning of culture to religion and "exoticism" (e.g. confusing folk wisdom with Qur'anic rules; explaining all cultural values from Islamic principles; over-attention for spirit-possession).

(2) mixed-up information of different cultures (e.g. most doctors make no difference between Turks and Moroccans because they are both Muslims, but there are also doctors who don't discriminate between Turks and Spaniards etc).

(3) assumption of uniformity within a culture (e.g. all foreigners' belief in supernatural causes of illness; all Turks and Moroccans are illiterate).

(4) failure to discriminate between deviant behaviour in a culture and the normatively accepted behaviour (this is mostly seen in assumptions about the family structure and family-relations).

These misconceptions have led to observation and interpretation errors and to stereotypes. Behind his culture (or his migrant status) the individual person is hardly recognised. The many individual and situational variations, that are so important for a differential psycho-social history in order to estimate the individual's coping mechanisms and their relation to illness (like the degree of religious devotion, degree of modernity, family relations, job constraints, the coping with migration, lifestyle, health-habits, neighbourhood constraints, etc.) are burried under the heavy load of culture, and ignored.

There is a vast body of literature, especially in psychiatry and ethno-psychiatry, that shows how strongly diagnoses are influenced by the way in which patients present their complaints (48-50) and by their familiarity with the language in which they present them. Proper behavioural interpretation may influence even the type of disease that is diagnosed. In other countries with large and divergent immigrant populations a vast body of literature exists on the (apparently widely) assumed "somatisation" of complaints in immigrants and the "lack of recognition of psycho-social origins of illness". Comparative analysis proved to be rather successful in tracing recipients views on origins of illness, in such widely different studies as on Mexicans or Chinese in the U.S.A., or eastern-European immigrants in Israel (51, 52). In many cases it turned out that the supposed denial of psycho-social origins of disease, was founded in ethnocentric observation-bias (53).

The persistent myth that (im)migrants do not recognise non-somatic origins of illness is the most outstanding example of not applying social sciences knowledge in the medical context, which has far reaching consequences on therapeutic decisions. Studies on folk beliefs on the origins of illness among Turks (27) and Moroccans (21) show that they recognise natural as well as interpersonal (social) and supernatural causes of disease. In medical conferences, courses and journals this knowledge has been transmitted (54), which predominantly caused a firm discussion on the phenomenon of spirit-possession ("exoticism") (46, 55). Shadid and Van Koningsveld (56) show on Moroccans that there exists a rich body of observations on psycho-social illnesses. In interviews with Moroccan immigrants they found at least four types of mental disturbances:

1. "wahm", a concept of which the symptoms resemble the western ones on vague, psychosomatic or psycho-social complaints. According to Jongmans (57) wahm can in the local theories originate in egoism, jealousy, criticism or/and loss of honour (respect). The word wahm refers to the series of consequences of these psycho-social factors. Its multiple meaning includes: sleepnessness, hypochondria, brooding, (bad) dreams, lack of appetite, absent mindedness, imaginations of illness, etc.

2. "waswas" appears to be a more psychiatric syndrome. Symptoms can be: (pathological) delusion of persecution, of jealousy, of suspicion.

3. "hmeq": incidental overagressive behaviour (including violence, unjustifiable behaviour, that goes with depression).

4. "djnoun": this may take two forms: hmeq or (spirit) possession. This term refers not so much to symptoms or illnesses but to a supernatural cause of several possible diseases.

There is an enormous pressure on researchers only to do research and formulate explanations which are immediately applicable to problems that medical personnel experience in taking care for migrants. This resulted in the lack of a frame of reference for the interpretation of data. Good, but fragmentary scientific explanations which are valid within a certain context, are applied to other situations in which they are not valid, or in which they need supplementation.

There also exists valid scientific information that is not used at all. This applies to information: 1) on strong stereotypes which existed before the information was gathered, 2) that is so general that it has to be applied differently in various situations, 3) that is difficult to use outside a somatic frame or reference, 4) that would cost the doctor extra time when applied. Examples of such information are the descriptions of important values on politeness and its influence on the presentation of complaints. Eppink (46) explained that patients may first present a complaint complaining extremely, in order to find out how the doctor reacts, treating a patient who does not pay him. However, there are no case descriptions which show how the doctor handled the first complaint politely, in order to discover the real complaint. Indeed, most case descriptions show all therapeutic guns to be fired at the first presented complaint. Several other authors (45, 58) stress that psycho-social aspects of complaints cannot be treated without first and foremost full recognition of the somatic part of the complaint. However, most case descriptions show that many physicians give two conflicting messages in the very first contact: 1) you are not ill, "nothing is wrong with you", 2) you get pills or/and you may be referred to a specialist. This message is to many migrated patients as clear as an overt statement that: "you are a malingerer" or that: "I do not want to take very much care of you".

Priorities in the management of problems

Research

Research on the recipients' view on problems will be inevitable to reveal concrete barriers in medical care (23, 59) and the whole range of processes influencing the healing process, therapeutic choices and patient compliance. Without such research medical personnel will never gain a proper concept of the interaction process between them and the migrants, as it is strongly influenced by their own behaviour and by the patients' perception of this behaviour.

Elimination of stereotypic explanations may also be given a priority. Attitudes and behaviour patterns are quicker set than changed and may unnecessarily influence medical care to second and even third generation immigrants. This elimination includes the habit of health care personnel to ascribe all patient's attitudes, behaviour and problems to culture instead of also considering the consequences of migration, social position, health history, risk factors, or interaction patterns in medical care. It also includes to get proper information on the prevalence of psycho-somatic complaints and on the immigrants' "denial" of psycho-social origins of complaints. The importance to understand and share the symbolic language and acts has been analysed and its communicational value and influence on acceptance of therapy is described in the North-African situation (60).

Such information not only makes us understand possible origins of problems in medical care, but a thorough analysis can offer tools to apply this knowledge in therapeutic situations. An example is Creyghton's beautiful description and symbolic analysis of the communication between doctor and peasant in Tunisia (61). She describes the nearly wordless consult of a meddeb (Qur'anic healer), who advises a father on the cure of his daughter, who was "shaking" and had "bound hands" (not literally). The meddeb diagnosed the origin of the illness as follows: 1) she fell ill on Thursday and 2) she was hit by a jinn (evil spirit) when she drew water out of the well. The educational part of this description is Creyghton's analysis of the symbolic meaning of this illness origin and its communicational and emotional scope. The message/diagnosis contains a twofold (contradictory) interpretation, an accusing one and one that pleads for innocence. The accusational part of the message is toward the father of the young woman: you do not let your daughter go out for water on Thursday evening because it is common knowledge that the jnunn (sing. jinn) are very active and dangerous at that day and time, especially near wells. The pleading part is: in every household you can run out of water at an inconvenient time and water is very essential. Toward the girl the double meaning is: you could know that jnunn were to be encountered, so you did not say enough prayers while going for water, and: jnunn are that violent late on Thursdays that they can hit you despite many and powerful prayers. It is up to the victim to decide which meaning he picks and he may keep this deep in his heart (or leave it beyond cognitive notions). This way the meddeb is never the one who makes him lose his honour in front of the community, which is a very central value in (rural) North African life.

Western doctors (including psychiatrists) do not give such beautiful double messages, respecting the patient's dignity. The double meanings of our doctors are culturally interpreted by their foreign patients as one single (accusing) meaning: your illness is only in your mind and you will fail if you do not cope better. However, you have to find out by yourself how to cope better. Such a message appears rude and impolite and does not show respect to the patient's essential values, nor his needs. However, as Eppink (46) shows convincingly, we appear to be just as contradictory ourselves in handling psychosocial backgrounds of physical complaints, and our messages are just as full of symbolic meanings as the North African ones. But since they are ours, we are often not aware of them and the (equally) strange explications that outsiders may give to them.

Health Care Policy

Aiming at solving the whole range of problems in medical care will certainly lead to disappointing results. However, there is enough knowledge to establish models and start to influence the negative vicious circle at levels that are susceptible for a change, levels at which problem-intervention is possible. Several "difficulty-levels" for intervention can be discerned:

1. Problems as a result of individual medical personnel's incapacity can be influenced, but to a rather vague level. Lack of knowledge can be influenced by education and post-graduate courses. However, thorough understanding of the variety of cultures, which the various ethnic categories represent, may be considered impossible. Therefore, organisational solutions will have to complement such education. Efficacious education aims at a knowledge that is sufficient for proper diagnosis of a type of illness and further referral to or cooperation with bilingual personnel, capable of handling the cultural, migrational and acculturational variables. Problems as a result of medical personnel's lack of interest or even resistance to deal with foreign patients are far more difficult to influence and they further stress the need for organisational solutions.

2a) Problems as a result of the organisation of health care are manipulable. However, efficacious manipulation demands careful study of existing possibilities and eventually new structures, their usefulness and their acceptability by both medical personnel and immigrants.

Successful initiatives of individual medical workers offer useful experience. The same applies to descriptions of solutions and to descriptions of doctor-patient, or traditional healer-patient contact, in the original culture.

2b) Problems as a result of the dominant bio-medical (cure vs. care) approach are difficult to handle within a limited period of time. Although this approach is in a process of change, such processes are usually slow and the outcomes are difficult to predict. Indirectly they can be influenced by education and by stimulation of research. Research aimed at manipulable implementation of psycho-social/cultural variables in healing is still "under-developed". However, without such general expertise, diagnosis as well as therapy will remain difficult when such variables play an important role in illness and illness perceptions.

3) Problems as a result of the immigrant's place in society are probably the most difficult to handle. Discrimination and its consequences, like constant fear (health hazard) and mistrust (influencing interaction also in the doctor-patient relationship) in the immigrant are one example. Another example is the "permanent temporarity" of the immigrants' stay in the Netherlands, with consequences for their adaptative reactions and other emotional strains. Besides, this type of problems is reinforced by the type of problems mentioned in 2b) and vice versa.

At present the levels of health care organisation and of education seem the most appropriate to start a new policy.

If properly rendered, western medical care has shown to be widely used in other cultures. However, especially in (properly diagnosed) mental or psycho-social (origins of) illness, traditional medical care that is assimilated in culture, often proved to be more successful than western medical care. This may apply to acculturational situations only to a certain, unknown, extent. Experiments with specially developed provisions for such situations show different results, depending on the proper connection of the new model to the acculturational situation (62).

In Dutch medical care there has been a considerable effort by individual health care workers to render satisfactory care to immigrants. Physicians, nurses, social workers and public health personnel who "invented" new adaptive models of care report far more positive results and satisfactory relations with their patients (14) than those who did stick to their familiar modes of service. The lack of a structural framework to impose such innovations in a wider context, certainly accounts for the low results of their efforts on the overall quality of medical care.

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CHAPTER III HEALTH CARE POLICY AND THE POSITION OF ETHNIC MINORITIES; PHILOSOPHICAL CONSIDERATIONS

Gaspard A. de Jong

Introduction

The health status of migrant workers and of ethnic minorities and the provision of health care for these groups are often perceived as problematic by policy makers. The fact that these groups receive special attention in many World Health Organisation research programmes may serve as an illustration of this point. In this chapter we will analyse to what extent such special attention on ethnic minorities in health care policy is justifiable or mandatory from a philosophical point of view. This will be done by applying four distribution principles to the position of ethnic minorities. The application of these principles is supposed to lead to an optimal distribution of resources. An example is the libertarian principle, which is popular at the moment in the United States and the United Kingdom. The governments in these countries believe that the market provides the best method to cater for people's needs and the governments should intervene as little as possible.

But first we must define what the specific problems of ethnic minorities are. This is not easy. There are several reasons for this:

- although the broad term 'ethnic minorities' is often used, and will be used in this chapter, it is rather vague. There are many different minorities in Europe: political refugees from various countries, minority-groups from former colonies, migrant workers from Mediterranean countries, etcetera. They are distinguished from the majority by the fact that they have not yet lived in the host country for several generations. But the majority, however, is also composed of groups with different cultures and socio-economic and political positions. Statistics of inequalities in health care show that there are large differences in health status within the majority.

- different groups within society have different interests in the definition of health (care) problems of ethnic minorities. The majority population for instance may see the problem as an increased risk of infectious disease, e.g. tuberculosis, imported from other countries. Health care providers are confronted with practical problems such as the language barrier. The patients from ethnic minorities themselves may perceive the problem differently again: the doctor does not recognize their illness and therefore does not respond to their problems in the way they expect.

- many problems of ethnic minorities are either not unique to those minorities or are problems that require solutions outside the health care system. Examples of the former are low income, unemployment, bad housing, which have significant negative effects on health status. These problems occur in large segments of the majority population as well. The most important specific problem of ethnic minorities, requiring solutions on a more general level, is that of discrimination. But one should recognise of course that discrimination adds to

> the first kind of problem. It is more difficult for a member of a discriminated minority to find a job and decent housing. Nevertheless there is no reason to treat the health problems which result from an unfavourable social position differently in minorities. Doing this could fuel discrimination among the members of the majority who live under similar circumstances.

In this chapter we will restrict ourselves to what seems to be one of the most important types of health (care) problem found among ethnic minorities: problems arising from cultural differences. This includes differences in definition of illness and disease, differences in social roles and problems of competence in the use of western health care systems. The analysis is further focussed on the question whether these cultural differences warrant special consideration in health care policy. This question will be analysed on the basis of a number of distribution principles derived from the dominant political philosophies in western countries: the libertarian, the equal access, the egalitarian and the utilitarian principles of distribution.

These distribution principles and their general implications for health care are described in the next section. In the section thereafter the specific health problems resulting from cultural differences are elaborated upon. This sets the stage for the analysis of the position of ethnic minorities in health care policy in the last section.

Distribution principles for social policy

The four distribution principles to be used in our analysis can be divided into two groups. In one group the principles deal primarily with the **process** of distribution. In the other group distribution is guided by **outcome** in terms of health status.

The first process-oriented principle is the **libertarian** principle. According to this principle distribution should be achieved by freely negotiated transfers in the marketplace. Within this philosophy, health care is also provided through market mechanisms. However, even the most ardent supporters of the libertarian principle realize that some people will be victims of the market and will not be able to purchase services. Therefore **charity** plays an important role in the provision of social services in the libertarian philosophy.

Most western countries have recognized that these mechanisms for distribution of services are not satisfactory. They have replaced charity by the **equal access** principle, in which the government guarantees every citizen access to a minimum of social services. In the Netherlands the obligation of the government to care for the health of its citizens has recently been embedded in the constitution. The equal access principle, which is rather typical of the so-called welfare states, is the result of political compromise. In most countries services have expanded on an ad-hoc basis and using different methods of financing and regulation. The result is a complex bureaucracy of services. One of the main drawbacks of the equal access principle is that it provides no guidance as to which services are to be provided and at which level.

Another problem which has only recently received attention is that equal access does not guarantee an **equitable** distribution. Within the equal access principle, it is assumed that everyone will use services according to their needs. Those who have greater needs will use more, others less. In reality this does not seem to be the case. This is especially relevent in the case of ethnic minorities (see the last section of this chapter).

Of the two outcome-oriented distribution principles the **utilitarian** principle is closest to the market-oriented libertarian principle. Economics is largely based upon the idea, that the individuals maximise utility when they trade on the market. If we transfer this principle to health care, services are to be provided primarily on the basis of cost-effectiveness analyses. Like the libertarian principle this would lead to an unequal distribution. It is likely for instance that more resources would be allocated to preventable and curable diseases than to care for the chronically ill and handicapped.

The **egalitarian** principle gives priority to care for the group and individuals that are worst-off in terms of health status. Identifying these is difficult enough considering the many approaches available to measure health status and the problems of measurement. But the problem becomes even more complex if one takes into account the possibility that perceptions of which groups are worst-off may vary with cultural and ethnic background.

In the analysis, presented in the last section of this chapter, we shall focus primarily on the dominant distribution principle in western-european welfare states; the equal access principle. A more extensive analysis of the application of the distribution principles to health care policy in general can be found elsewhere (1).

Health status of and health care for ethnic minorities

Health is influenced by many factors: adequate supply of food and water, protection against climate, socio-economic factors, environmental factors, cultural and behavioural factors, health services, biological factors and a number of unknown factors. Although the influence of each factor is not exactly known, one can safely say that the provision of health services is not among the most important determinants of health (2).

It is difficult to say whether the health status of ethnic minorities is worse than that of majority-groups in similar socio-economic positions. In most European countries adequate health statistics on this point are not available. American health statistics on blacks and Hispanics do suggest specific disadvantages in terms of health status. The findings of occasional surveys in Europe are less clear.

A number of points should be made however:

(a) Although health services in general can do little to remedy the consequences of poverty (a common condition for ethnic minorities) there are a few areas in which they do make a difference (3); e.g. preventive services, mother and child health care and care for the chronically ill.

(b) Health statistics are usually based only upon a limited disease-oriented approach to health status.

(c) Health services are an organised social response to illness. They are not just a neutral technical instrument, but they also fulfill important social roles. There are different views and theories on health services as a social institution. But one clearly important function with great practical significance is that of legitimising illness. The feeling of the illness being recognised is important psychologically for the patient. In welfare states the legitimation of illness is essential as a means of obtaining social security benefits.

On each of the above points differences in cultural background can create problems:

- the idea of prevention, of seeking help when one is not ill, is strange to many cultures. In western countries the degree of participation depends to a large extent on the level of education;
- birth and child-rearing are seen in many cultures as areas in which the mother is quite competent. The preventive function of services for mother and child is not easily recognised;
- in her study of Turkish women in Sweden, Lisbeth Sachs describes vividly that these women feel their health has deteriorated after migration (4). This is probably not reflected in official statistics, since it represents a more subjective approach to health status. To the women concerned it is probably fully valid.
- the language barrier, which exists with some migrant-groups and ethnic minorities, is a technical problem which easily hides the more fundamental cultural barrier. Each culture provides its own explanations, diagnostic categories and expected responses for illness. From the point of view of the western scientifically trained health care providers the response to illness in other cultures may be found to be primitive or harmful: not consulting a doctor for some serious disease or expecting the doctor to prescribe powerful medication. In some cultures psychological explanations of illness do not exist. This of course creates problems of communication in western health care systems, where such explanations are quite common.

More detailed analyses of the health (care) problems of ethnic minorities can be found in other chapters in this book. For our purpose we can summarise them as follows:

(a) From the point of view of "modern medicine" there are a number of diseases among ethnic minorities that could and should be treated more effectively. From this point of view these patients exhibit a lack of competence in the use of modern health care.

(b) western health care fails in fulfilling its social roles in the response to illness amongst ethnic minorities. Therefore these minorities wish to consult their own healers: folk healers or scientifically trained doctors with the same cultural background.

The two problems are related. One might expect that as competence in the use of western medicine grows and as western culture is adopted, the need for use of traditional healers will decline. This shift has also occurred in poor and rural segments of the majority population (5).

On the other hand, the western medical culture has also adapted to changes in its environment. The present popularity of psychological and social explanations of symptoms and diseases is partly due to the fact that western patients have become more and more dissatisfied with being treated as biological objects. Western medicine may likewise learn from and respond to the health cultures of ethnic minorities.

Justice, health (care) policy and ethnic minorities

In this section we shall mainly deal with the implications of the equal access principle: are ethnic minorities treated equitably?

Before doing so, we will briefly discuss the consequences of the other principles. Application of the **libertarian** principle could lead to interesting results. If health care for ethnic minorities is left to the market a number of things could happen:

- western health care institutions in areas with a large number of inhabitants from ethnic minorities may make an effort to attract more patients by adapting to the patients' wishes and expectations; e.g. good interpreters, flexible appointment schedules.
- In the **market** there would also be room for traditional healers. Payment of healers for their services is after all quite normal in many cultures.

Unfortunately this optimistic picture is probably incorrect. It is more likely that western health care providers will be more attracted to the majority-groups with higher incomes. And apart from a number of idealistic workers (charity) the poor areas with large numbers of patients from ethnic minorities will probably be more attractive to providers with less than optimal ethical and professional standards, out to make a quick profit.

With the **utilitarian** principle there is first of all the problem whose utility is to be used as a starting point. If we use the utility of the majority, an extra investment aimed at increasing the competence of ethnic minorities in the use of western medicine will probably be warranted. An improvement in health status, e.g. in reduced infant mortality and morbidity, can probably be achieved at relatively low cost. If, however, we take the utility of the ethnic minorities themselves as a yardstick the extra investment would perhaps be directed to expansion of the traditional care system in the host countries. But of course one cannot generalise here; there is diversity within the minorities as well.

Application of the **egalitarian** principle gives the same kind of problem. But in any case the patients from ethnic minorities will be regarded as worse-off than patients from comparable majority-groups. Their lack of competence in the use of modern medicine puts them at an extra disadvantage. But they are also disadvantaged in the sense that they have less access to healers that from the point of view of their own culture, can respond adequately to their illness.

These considerations are also valid with respect to the application of the **equal access** principle. Western countries provide their citizens with an easily accessible health care system according to western standards. Ethnic minorities are also free to use this system.

As discussed in the preceding section the realities of this equally accessible system are less than ideal. In general the equal access policy of western countries has been realised by removing financial and organisational barriers to the use of services. For the majority this has largely had the desired consequences, although one could question whether this is also true for the poor (6). Apart from the fact that migrants tend to live in slum areas of big cities, which are often underserved, they are faced with a number of specific barriers; language, competence and culture. As long as these barriers are not removed, one cannot say that access to health services is equitable for ethnic minorities. How these barriers are to be removed is another matter, which is discussed in other chapters and in the report of the consultative group (7).

An interesting problem within the context of this chapter is that of the traditional or folk healers. Although the policy in western countries is based upon the assumption that ethnic minorities will eventually learn and adopt western medical culture, traditional healers still play an important role for some groups. Sometimes healers or physicians are consulted at great expense by travelling to the country of origin if treatment cannot be delayed until the summer holiday.

In the past traditional healers have been regarded and sometimes even persecuted as quacks in western countries. This attitude is rapidly changing due to the fact that traditional healers and 'alternative medicine' are being consulted widely, more openly and more frequently. They are now tolerated. The next step, which is being discussed in the Netherlands, is coverage of alternative medicine by (public) health insurance. Opposition is strong, for economic reasons and for medical reasons. Both reasons can be questioned. Economic problems of rising health care costs can be solved by rearranging priorities; restricting new additions to the system is a rather arbitrary policy. The medical reasons, unproven effectiveness of traditional healers and alternative medicine, are only valid within a medical frame of reference. The patients using these healers obviously have other views on their effectiveness.

The question is whether governments have an obligation to cater for all health cultures. This would not seem to be the case. The (constitutional) obligation goes no further than the provision of a minimum of services, arranged in accordance with the dominant culture. Therefore barriers to the use of modern health services should be removed as much as possible. At the same time other cultures must be tolerated.

Removal of barriers to health services is especially important in view of the changes in health care policy which are under consideration. In general, policy makers seem to consider that too much use is being made of the health services. They therefore try to introduce disincentives for the consumer (cost-sharing) and for the provider which might reduce medical consumption and consequently the costs of health care. Migrants and ethnic minorities are in a vulnerable position here because this would mean another barrier to the use of services. The effects of financial barriers on the behaviour of ethnic minorities deserve special consideration.

Conclusion

The question posed at the beginning of this chapter can be answered affirmatively. Ethnic minorities deserve special attention in health care policy. But only to the extent to which their problems are greater than those of comparable majority-groups. In practice this means removal of the language barrier and accommodating the shift to western medical culture and helping them to gain competence in the use of the western health care system. When introduction of new financial barriers to the use of health services is considered the possible effects on the behaviour of ethnic minorities should receive adequate attention.

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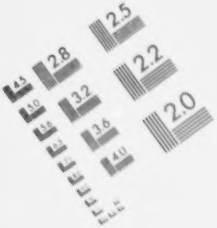
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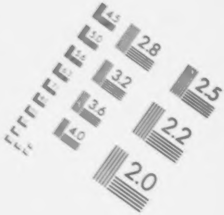
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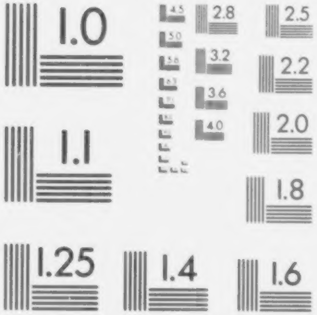
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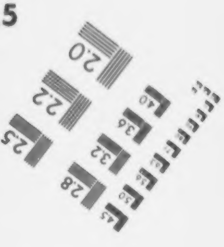
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PART II

HEALTH CARE RESEARCH AND EVALUATION IN A HOST COUNTRY: THE NETHERLANDS

INTRODUCTION TO HEALTH CARE RESEARCH AND EVALUATION IN A HOST COUNTRY

M. Colledge and P-G. Svensson

In this section van Geuns and Hoolboon address the questions of health care and research respectively. Although their comments are based on the experience of migration to the Netherlands by Turkish and Moroccan immigrants, a number of central issues emerge which are common to most northern European countries. Historically the initial response of many governments dealing with waves of immigration has been to see the newcomers medical and health care within narrow confines. Reactions have been to identify special characteristics and differences of disease distribution. Firstly, by looking specifically at infectious diseases, such as tuberculosis. During the sixties and into the seventies medical research has tended to experience differences in migrant populations with the narrow confines of pathology, rather than look at the social and environmental factors. This strategy in itself led to a restriction on the data available for wider research.

It is evident from both writers that there is a need to improve the databank for migrant groups, most of the evidence is fragmentary and cannot be readily adapted to policy. It is also clear from van Geuns' comments that we should question what sort of data do we need, what is its value, and to what purpose will it be used? We must be sensitive to the dangers of stigmatisation and victim blaming, and see from experience that an over concentration of differences in disease patterns on a race basis, not only misses a number of the real health care needs of migrants, but also tends to lead to scapegoating the migrant as a source of infection and contamination. Within this category the way tuberculosis has been highlighted and researched is classical of this particular perspective.

Also there has been a tendency, historically to think of providing separate health care facilities to meet the **special needs** of migrants. This form of medical apartheid is based on the false assumption of research to date. Both writers' comments reinforce the need for integration and not separation when planning health care initiatives. Special needs as shown earlier by Spruit are later in this book by Broekx and others are more linguistic, and can be responded to within existing frameworks of care by a sensitivity to what the migrants themselves see as problems.

Finally, this section illustrates the importance of a reflective approach to research policy and methodology. As Hoolboom comments the Dutch and the immigrants attach different meanings to the concept of illness and define it according to their own frames of reference. Qualitative methods can tease out the problems of language and meaning, and an ethnographic approach can add flesh to the descriptive statistical analysis usually applied to quantify the needs of communities.

CHAPTER IV HEALTH CARE AND TURKISH AND MOROCCAN IMMIGRANTS

H.A. van Geuns

When the Netherlands began to attract unskilled labour from seven different countries to meet the demands of the explosive economic growth of the 1960s, it was not envisaged the impact this would have in health care provision fifteen to twenty years later in the Netherlands, or the necessity to look at the broader aspects of prevention and socio-cultural dimensions. Initially, medical concern was confined to physical examination: labour was the commodity required and the criterion for selection was physical fitness. However, two agencies in particular, the Chief Medical Officer of Health and the Directorate-General for Manpower, soon came to realise the necessity for more intensive consultation on medical problems, as did the Royal Dutch Medical Association, which informed the then State Secretary for Social Affairs and Health as early as 1971 that opportunities for consultation were needed.

In response to these requirements the Minister of Health and Environmental Protection set up in 1972 the Board for Medical Care for Migrant Workers, whose task was to advise the Minister on the provision of medical care for foreign workers. The **Board's first report** related to the period between September 1972 and September 1973 and outlined the problems dealt with in that first year. The first important problem was **difficulty with the language.** According to the report this did not merely involve the inability to speak or understand Dutch: it expressed a cultural **difference in thinking,** and meant that the patients' **psychological problems in particular** went largely unheeded. The report advocated separate medical centres for foreigners, employing not only doctors and other medical staff, but also social workers and interpreters. In the 1974 report the Board discussed in detail the arguments against bringing to the Netherlands doctors from the same countries of origin as the foreign workers.

It issued a report in favour of setting up pools of medical interpreters, which resulted in the creation of five government-subsidised centres.

Working on the principle that this activity should not be subject to financial constraints, the Ministry of Health and Environmental Protection undertook to subsidise the cost and continues to do so. A thorough evaluation of the interpreting centres appears in a report that has now been published. A subsequent report on providing information for foreign workers resulted in the establishment of the Health Care Information Centre for Migrants, which was set up on the joint initiative of the National Home Nursing Association and the Netherlands Red Cross and has been subsidised from the onset by the Ministry of Health and Environmental Protection.

It was gradually realised that serious consideration would have to be given to the fact that a large proportion of the immigrant population were here to stay, if not permanently then at least for a very long time. Furthermore, the mid 1970s saw immigrant workers joined by their families, which led to new problems relating to the provision of health care for workers' wives and the rapidly growing second generation. In 1979 the Advisory Council on Government Policy published a report on ethnic minorities. The report was the first document to state clearly that the Government would have to bear in mind that fact that large groups of foreign workers were here to stay for quite a while at least (1).

The Board for Medical Care for Migrant Workers had gone further into the significant problem posed by psychosomatic illness and had formulated the problem thus: 'Health workers see foreign workers with psychosomatic disorders that are difficult to analyse and almost impossible to treat in the normal way. In many cases the disorder has no medical cause but is as it were a sign of underlying problems that are often very complex'.

The Ministry of Home Affairs had in the meantime assumed responsibility for coordinating a response to the problems of ethnic minorities. A civil service Interministerial Committee on Minorities Policy was set up, comprising a number of working parties, including one on health, on which the Board was represented by its chairman, a civil servant. The Board recently initiated a study of the efficiency of the child health centres and nursery facilities catering for the children of foreign workers. A study of the psychological problems of school children and adolescents has also begun, and ways in which they might be helped by school doctors and the various outpatient mental health care services are being investigated.

Any attempt to discuss the health of foreign workers is continually hampered by the lack of statistics relating to illness. None of the relevant bodies (e.g. the authorities responsible for implementing social security legislation the health insurance funds, their records departments and those of the hospitals and medical insurance companies, and the Central Office of Statistics) systematically record the nationality of their patients or clients. Thus it is practically impossible to obtain data on which to base a policy and determine what is required in the way of extra facilities. The only fact relating to Turks and Moroccans that can be established with any certainty is that their numbers have doubled since 1975. Table 1 shows that

Moroccans increased as a percentage of the population from 0.24% (33,200) in 1975 to 0.51% (71,800) in 1980. During the same period, the number of Turkish immigrants increased from 62,900, to 119,600, or from 0.46% to 0.85% of the population. Taken together, the two groups grew from 95,800 or 0.70% of the population to 191,400 or 1.36%. If illegal immigrants are taken into account, the number must be well over 200,000, or almost 1.5% of the total population.

Tuberculosis in Turkish and Moroccan Immigrants

One of the first responses of the Netherlands government was to test foreign workers for tuberculosis (TB) when they began to arrive in large numbers. Considering the high incidence of the disease in most of the countries from which foreign labour was recruited, it was certainly not inconceivable that patients would arrive in the Netherlands to start work suffering from an active form of pulmonary tuberculosis. This directly explains the government's second concern - the risk of these patients infecting Dutch citizens. There was also the fact that the incidence of those infected with tuberculosis, indicated by a positive tuberculin test was bound to be much higher than among comparable groups in the indigenous population. In 1961 the tuberculin index among Moroccan aged 18-23 was 83% (the index is the percentage of those infected with tubercle bacilli and therefore reacting positively to the tuberculin test.) This figure is six times higher than the 14% registered for Dutch people in the same age group in that same year.

In 1971 Turkey carried out tuberculin tests on children aged 6-15 who had not received BCG vaccination. Positive reactions amounted on average to 15%, as opposed to 1% for comparable age groups in the same year in the Netherlands. A secondary form of

Table 1

	Moroccans		Turks		Ratio	Total		Netherlands
	x 1,000	%	x 1,000	%		x 1,000	%	x 100,000
1975	33.2	0.24	62.6	0.46	1 : 1.9	95.8	0.70	13.6
1976	42.2	0.31	76.5	0.56	1 : 1.8	118.7	0.87	13.7
1977	48.6	0.35	85.2	0.62	1 : 1.75	133.8	0.97	13.8
1978	55.4	0.40	95.2	0.68	1 : 1.7	150.4	1.08	13.9
1979	64.0	0.46	106.8	0.76	1 : 1.65	170.8	1.22	14.0
1980	71.8	0.51	119.6	0.85	1 : 1.67	191.4	1.36	14.1
1975 - 1980	More than doubled		Almost doubled			Doubled		

Source: Central Bulletin of Statistics.

Table 2: Foreign workers arriving in 1975 who respond to the request that they should be screened.

	Total absolute figures	%
Arrival	1758	100
after 6 months	1380	78.5
after 1 year	1092	62.1
after 1½ years	824	46.9
after 2 years	648	36.9
after 2½ years	511	29.1
after 3 years	398	22.6
after 3½ years	287	16.3
after 4 years	154	8.8
after 4½ years	20	1.1
after 5 years	7	0.4
after 5½ years	0	0

tuberculosis, in many cases pulmonary amongst which the contagious types arises in tuberculin positive patients, particularly those who find themselves in adverse physical and psychological circumstances, such as might be caused by a different climate, different customs and habits, living conditions that are bad and sometimes unfit for human habitation, different food or homesickness for their families, homes and mother country.

For the reasons outlined above the TB centres, which carry out medical examinations of immigrant workers on arrival were requested to continue screening them for at least three to five years thereafter. In practice this proved to be more difficult than was initially thought, as immigrants are quick to change jobs and even quicker to change their address. In addition, the various notifications issued by the TB centres are often not understood. A recent study in the annual report of the TB centre in The Hague showed that a three year programme was successful in screening only 20% of immigrants. If extended to four years the figure is only 10% (Table 2).

The same report also contained an analysis of the ways in which one hundred and fifteen cases of active tuberculosis in immigrants were detected. Fifty were discovered during examination at the TB centres: thirty-two during the first examination on arrival, ten during the first year and five in the second year. Forty-nine cases, i.e. 42% were discovered when the subjects complained of symptoms to their doctors who referred them to the TB centre or a specialist. Twenty-three of the thirty-two cases of infectious TB were detected by the general practitioner. These figures show that there is little point in the TB centre periodically screening foreign workers for longer than a year. Firstly, technical resources make it almost impossible, and secondly immigrant workers tend to be as prompt as the Dutch in consulting their doctors.

There is however, insufficient awareness of the fact that TB can arise years after arrival. To give some idea of how much time can elapse between arrival and the onset of tuberculosis an analysis was carried out of 2121 cases of active tuberculosis detected between 1965 and 1970. 42% were discovered on arrival or within the first two months; 21% between two and six months; 10% in the second half of the year after arrival and another 10% during the second year. In 12% of cases the disease occurred after the subjects had resided here for more than two years: (Table 3).

Second generation immigrants constitute a complicating factor. Many Turkish and Moroccan residents spend vacations in their homeland, taking their children who were born in the Netherlands. The children come into contact with a population in which tuberculosis is rife, and within a few months or even weeks of their return they are found to have primary tuberculosis or sometimes meningitis. This has occurred regularly in the past. As a result, BCG was added several years ago to the programme of vaccinations for these children. The vaccine is administered after the third combined diphtheria-whooping-cough-tetanus-polio injection, i.e. at about the age of six months. If the child has been in the Netherlands since birth, a preliminary tuberculin skin test is not absolutely necessary. Children coming to the Netherlands who have not been vaccinated but who react negatively to the skin test are also given BCG vaccine.

To what extent can the fact that there are relatively large numbers of foreigners with tuberculosis in the country have an adverse effect on TB incidence among the indigenous population? In April 1975 a WHO working party in Berne engaged in monitoring tuberculosis in foreign workers (2). It contained comparisons of the frequency of TB per 100,000 of the indigenous and immigrant population and showed that the frequency of all forms of tuberculosis is fifteen times higher for foreigners than for Dutch people. If the figures for 1979 are looked at similarly, they reveal that foreigners accounted for over a quarter of all known TB cases in the Netherlands. The figure varies from 27% for pulmonary tuberculosis to 19.1% for other forms of the disease, i.e. those not affecting the lungs. Per 100,000 of the population the frequency of tuberculosis is shown to be eleven times higher among foreigners than among the native-born Dutch population. The frequency of pulmonary tuberculosis is 12.4 times as high (Table 4).

Do these figures indicate that the indigenous population run an increased risk of infection? During the past fifteen years foreign patients with open pulmonary tuberculosis have been known to infect Dutch people only on very few occasions. This may be due in part to the fact that while we speak, or at least used to speak of guest workers our hospitality rarely went as far as forging close social links.

The concept of risk of infection, an approach that relies more on epidemiology and statistics, offers another way of establishing to what extent the import of people from a country with a high incidence of TB poses a threat to the population of a host country with a low incidence of the disease. In 1975 Meijer calculated that the infection risk in the Netherlands was three per 10,000: i.e. that three people out of every 10,000 were infected with tuberculosis each year. To increase the risk to, say, four per 10,000 by the inclusion of another population with an incidence of TB that was 15-20 times higher would require an extra 700,000 people. This means that the presence of 200,000 or so Turks and Moroccans in the Netherlands can have no significant effect on the infection risk for the indigenous Dutch population. While it should be borne in mind that the possibility of TB being present is 15-20 times as great in Turks and

Table 3: Length of time between arrival in the Netherlands and diagnosis of active tuberculosis. All forms, both sexes, all ages.

1965 - 1970: 2121 cases

Length of time	Absolute figures	%
< 2 months	899	42
2 - 5 months	454	21
6 - 12 months	208	10
13 - 24 months	202	10
> 2 years	259	12
unknown	99	5
TOTAL	2121	100

Source: Chief Medical Officer

Table 4: Cases of active TB in 1979.

Total number of foreigners: 435,000

	Total		Foreigners		Dutch/foreign	
	abs figs: 100.00		Abs figs % : 100,000		per 100,000	
Primary TB	256	1.8	63	(24.6)	14.5	1 : 10
Pulmonary TB	1148	8.1	318	(27.7)	73	1 : 12.4
Other forms	361	2.6	69	(19.1)	15.9	1 : 7.6
TOTAL	1765	12.5	450	(25.5)	103.4	1 : 11

Moroccans than in native Dutch people, the fear that the latter run an increased risk of acquiring the disease is completely unfounded.

[illegible] 110

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CHAPTER V: THE PROBLEMS OF RESEARCH INTO HEALTH AND HEALTH CARE, WITH PARTICULAR REFERENCE TO ETHNIC MINORITIES

H. Hoolboom

The purpose of research into health and health care facilities is to gain information on the state of health of the population of the Netherlands (or certain sections of it) and the effectiveness of the facilities available.

The question under consideration is what types of data can be used as a basis for conclusions. For the purposes of research into health matters we distinguish between data which are already available (general records, medical records in the curative and preventive sectors, research data) and data collected for specific purposes (medical examinations, questionnaires and interviews).

Research into the effectiveness of health care is concerned with both the use of facilities and the quality of the care. A major obstacle to research is the absence of data collected on a systematic basis. Another problem is the fact that native-born Dutch and foreigners apply different frames of reference to both health and health care. Cooperation is needed between health and health care researchers and those studying the cultural backgrounds of ethnic groups.

Introduction

When considering the problems of research into the health of ethnic minorities it should be asked what the purpose of the research is. In the context of this symposium it is clear that we are referring primarily to research which can assist the government with its policy. A question of particular importance is what specific provisions should be made for the ethnic minorities, given that those working in the health services have indicated that there is a need for this. The research is concerned both to detect any differences between the state of health of members of ethnic minorities and that of the native-born Dutch population and to assess the effectiveness of the facilities created by the government for the former. It should be realised that there is often a connection between the existence of a facility and the health of a particular section of the population. Vaccination of young children against poliomyelitis, for instance, has virtually eradicated this disease in the Netherlands, and it is hoped that the inoculation of young girls against measles will reduce the incidence of congenital deformities in their children by preventing them from catching German measles during pregnancy.

From the policy point of view special consideration needs to be given both to health and to the quality of the care provided. In addition, research ought to provide information on the factors associated with these. It should be remembered that assessments of health and well-being and of the adequacy of the facilities are influenced by social ideas.

In this chapter I intend to consider the problems which occur when carrying out research into health and health care in ethnic minorities. As regards health, I shall deal first of all with the research based on existing data, and then with that based on data collected for specific purposes. As regards health care, I shall distinguish between research into the use of facilities and that into the quality of the care.

Health

As already indicated earlier, assessments of health are influenced by the frame of reference applied by the various sections of the population. In general, however, it is true to say that generally accepted signs of illhealth, for example, clearly recognisable physical and mental deviations, define the concept of sickness.

People's complaints about their health and their psychological and social well-being can also suggest the presence of illness. In this case both the nature and intensity of the complaints are important factors. The way in which people experience health or sickness not only differs from one individual to another but is also influenced by the set of standards and values obtaining within a particular community. It is difficult, therefore, to define health, and allowance must be made for this when carrying out research.

In general, research into the state of health of particular sections of the population can be conducted in various ways. Attempts could be made, first, to detect differences between various sections on the basis of data contained in general records or medical files in the curative and preventive sectors of the health service or collected for research purposes. On the other hand it is possible to collect information oneself in relation to a specific question, for example, by carrying out medical examinations, using questionnaires or holding interviews. Both approaches have certain drawbacks, such as the uniformity of data collection and the choice of health parameters. Additional problems are associated with research into the health of people with different ethnic background and these will be considered one by one as the various types of data are discussed.

Research based on existing data

Various parameters can be used to assess the health of a section of the population. Growth in terms of height and weight, the incidence of clearly defined clinical pictures, and deaths in various age categories may be regarded as the more definite indicators of health. Pathological behaviour in the form of complaints reported, absenteeism from work due to sickness, drug-taking, for instance, and perhaps petty crime, provides additional information which can be used to assess the health and well-being of a section of the population.

If data of this kind are to be used in research they must have been collected and recorded in a uniform way and be available for the relevant section of the population.

In the remainder of this chapter I shall first give a general account of the value of various records systems to research into the health of ethnic groups in the Netherlands. Then I shall deal with the data from medical records in the curative and preventive sectors of the health service, and lastly I shall consider the use of research data.

Records systems

The Central Bureau of Statistics records demographic data on all residents of the Netherlands. The population statistics contain information on deaths classified by nationality and age category (see Table 1). These data are thus available on all foreigners legally resident in the Netherlands (Verhoef & Tas, 1980).

Causes of death are recorded separately. The two data systems can in theory be linked up - but only with the consent of the State Health Inspectorate.

Table 1 Mortality per 1,000 for different age groups. Dutch and other nationalities.

	0 - 9 years	10 - 19 years	20 - 29 years	30 - 39 years	40 - 49 years	50 - 59 years	60 - 69 years	70 years and +	Total
1975 - 76									
Dutch	1.3	0.4	0.6	1.0	2.7	7.2	19.2	73.8	8.4
Other	1.5	0.5	0.8	1.0	2.2	7.8	20.2	61.0	3.3
TOTAL	1.3	0.4	0.6	1.0	2.7	7.2	19.2	73.7	8.3
1976 - 77									
Dutch	1.2	0.4	0.7	1.0	2.7	7.0	18.8	71.0	8.3
Other	1.5	0.3	0.7	1.0	2.0	5.8	16.6	47.6	2.7
TOTAL	1.2	0.4	0.7	1.0	2.7	7.0	18.8	70.8	8.1
1977 - 78									
Dutch	1.2	0.5	0.7	0.9	2.7	7.0	18.4	69.5	8.2
Other	1.7	0.5	0.6	1.0	2.1	4.8	14.4	41.0	2.5
TOTAL	1.2	0.5	0.7	0.9	2.7	6.9	18.4	69.3	8.1

In theory research could be carried out into the causes of mortality among various ethnic groups in the Netherlands. It should be pointed out that those who have obtained Dutch nationality by naturalisation cannot easily be found in these records systems.

Illness

Information on the incidence of defined clinical pictures can be obtained from various sources. The Medical Registration Foundation (SMR) publishes statistics on diagnosis and treatments carried out on hospital patients. The nationality of patients is not recorded when they are admitted to hospital, however; consequently it is not a simple matter to research the incidence of certain illnesses among foreigners admitted to hospital.

General practitioners provide weekly information to 48 monitoring units on certain illnesses and events for which patients have consulted them. Every year the headings to be printed on the weekly report forms are decided upon by a planning committee. To date no information has been collected on the incidence of illnesses specifically among non-Dutch patients. Inquiries should be made to see whether this could be done in the future.

The public health inspector with special responsibility for tuberculosis control keeps data on the incidence of tuberculosis classified by nationality, which are suitable for epidemiological research: consequently there is no problem here (van Geuns, 1981).

Growth curves

Medical examinations of children in the juvenile health service include recordings of both height and weight. A few years ago these data were used to draw a growth curve for Dutch boys and girls (Van Wieringen, 1972).

In theory it should be possible to draw a growth curve for children of members of ethnic minorities resident in the Netherlands, but this can only be done if a representative sample of these sections of the population makes use of the juvenile health service. Very little is known as yet, however, about the use made of these facilities by foreigners.

Sickness absenteeism

The Netherlands Institute for Preventive Health Care (NIPG/TNO) has been recording statistics on absenteeism from a sample of enterprises in the Netherlands since 1946, but the nationality of the employees is not recorded separately. The same is true of the annual report of absenteeism and its presumed causes in each industry, published by the Social Insurance Council. Neither of these systems can be used as a basis for research into absenteeism among foreign workers as an indication of possible ill health.

Medical records in the curative and preventive sectors

Medical records can also be used to obtain an impression of the incidence of illness or health deviations in people who consult doctors. A distinction should be made between people who approach a doctor or some other professional helper with symptoms or complaints about their health and those who are examined by health service workers as a part of preventive health care. Data from the regular reports of both sectors could indicate the need for specific research projects to be instituted. Apart from the more general problems of setting up indicator systems of this kind, account should also be taken of associated problems when investigating the health of migrants as I shall now describe.

Information from curative medicine

In day-to-day medical practice it is extremely difficult in many cases to reach an unambiguous diagnosis on the basis of the complaints reported and examination of the patient, even if the doctor and his patient apply the same frame of reference. It is even more difficult for the doctor to interpret the symptoms if the patient presents them in an unfamiliar way: a symptom may have a distinct symbolic value to a patient of a different ethnic background. If the doctor applies his own frame of reference when deducing his diagnosis from his observations it will be of very limited value as a basis for research into the state of health of certain categories of patients. The same is of course true of the classification of psychiatric diseases among alien patients according to the western system.

Trials are currently taking place in various places in the Netherlands to see what happens when clinical pictures are classified with the aid of problem-oriented medical records in general practice. It is worth considering whether specific health problems among different ethnic groups might not be brought to light if special attention were to be focussed on them. The problems cannot be defined, however, without the aid of experts on cultural backgrounds. A distinction must be made between the way the professional helper and the help-seeker define the problem. The 'reason for encounter classification' recently described by Lamberts (1982) is a move in this direction.

Information from preventive health care

Data obtained from preventive medical examination - whether in the juvenile or the industrial health service - are not a suitable basis in many cases for research into the health of sections of the population, including foreign workers for instance. This is due to the fact, first, that the data are not collected in a uniform and standardised way, and second, in many cases the examining doctor or nurse's opinion is implicitly recorded on the file.

The Institute for Preventive Health Care's preliminary survey of the health of Turkish and Moroccan babies and toddlers and the care they receive in the juvenile health service made it clear to the researchers that only a small proportion of the information recorded by the child health centres can be used to detect differences between the health of Dutch and foreign children. Special consideration will therefore be given to selecting the health parameters for the full survey.

Another point worthy of consideration when assessing the state of health of foreign children in the Netherlands is whether this should not be compared with that of children in the home country. Here again, the frame of reference plays a part: a growth curve which is not as good as that of Dutch children may be better than that of children in the home country.

Research data

Lastly, an attempt could be made to detect specific complaints among foreigners by means of secondary analysis of, say, questionnaire data obtained from a population including non-Dutch nationals. The problem here, however, is that whereas 'ethnicity' is often one of the variables included in the survey, no distinction can be made between the different ethnic backgrounds of the respondents. A Moroccan and a Turk, for instance, although both Moslems, have different standards and values. In other words, one should be very cautious before making pronouncements on their health on the basis of secondary analysis of data obtained for another purpose.

Research based on specially collected data

As indicated at the beginning of this chapter, specific sections of the population could also be approached directly for the purpose of investigating their health. Depending on the object of the inquiry, medical examinations could be carried out or physical and mental well-being could be investigated with the aid of questionnaires or interviews. In the next section I shall look briefly at medical examinations; I shall then consider the problems which occur when carrying out research with the aid of questionnaires and interviews.

Medical examinations

Various problems arise when collecting data with the aid of physical examinations to answer questions which are not primarily concerned with the diagnosis of disease. The researcher, usually a doctor, is accustomed to reaching a diagnosis on the basis of a combination of the patient's complaints and the results of a physical examination, supplemented by laboratory and X-ray studies. Here the physical examination provides only part of the information; the remaining information compensates for any inaccuracies in the measurement of, say, blood pressure or heart size.

When comparing sections of the population, however, it is essential for the data to be collected and recorded in a uniform way. This requires a precise report form for the physical examination and standardised measurements. An additional problem when examining allochthons is that both physical examinations and the taking of blood and urine samples are regarded as taboo (Timocin, 1981: Verveen-Keulemans, 1981). Consequently special measures need to be taken to solve this problem.

Questionnaires and interviews

Research into subjective health and psycho-social problems in particular sections of the population can be carried out either by means of personal interviews or by having the respondents complete questionnaires. Aside from general considerations of methodology, such as sampling techniques and the representativeness of the sample, it is highly important to consider whether a questionnaire which is valid for Dutch people can be presented to those of a different ethnic background without modification. Examples are the Amsterdam Biographical Questionnaire (Wilde, 1963), which was used to measure the degree of neuroticism, the Subjective Health Questionnaire (Dirken, 1969), which dealt with psycho-somatic complaints, and the questionnaire used in the survey of how employees function (Dijkstra, 1981). More detailed research is needed to resolve this point.

Entirely practical considerations also play a part here: mistakes could be made, for instance, in translating a questionnaire into Turkish or Arabic, or the translator may be unable to express the idea behind the question effectively. This latter point may be even more important if a particular question is designed for a typically Dutch context. The answer may thus have doubtful validity as regards the true state of the foreigners' experienced health.

In the case of personal interviews, allowance must be made for the fact that the interviewer is influenced by his own ideas and prejudices when interpreting the answers (Selltiz and others, 1968).

Problems of this kind could no doubt be obviated by using interviewers who preferably both know the respondents' background and speak their language. With this in mind the Institute for Prevention Health Care decided to use Dutch students from the University of Leiden studying Turkish, in their preliminary survey of the psycho-social problems of Turkish adolescents.

Efforts should also be made to create a situation in which the interviewee can speak freely. Obviously this is particularly difficult in the case of girls and women, who are permitted to be questioned only if their male relatives are present.

Research into factors which affect health

From the policy point of view it is important when investigating the health of sections of the population to consider the factors which may affect this, for instance living conditions and ethnic background. If, for example, a large amount of sickness absenteeism is found among a particular group of foreigners, it may be worthwhile to compare it with that of Dutch people living in the same neighbourhood, making the necessary corrections for age and type of work, of course. If it is then found that the absenteeism is the same in both groups, the amount cannot therefore be attributed to 'foreignness'. Where ethnic minorities are concerned it is also very important to distinguish between (a) factors related to 'being an allochthon and (b) the aspects related to 'being a migrant' as such, and for instance, to specific age ranges (adolescence). In other words, control groups from the Dutch population and if possible compatriots in the home country or another host country should be used in the research.

The representativeness of the sample and control groups, then, must be subject to strict standards. The absence of specific demographic data is likely to be an obstacle in many cases.

Health care

As soon as migrants began coming to the Netherlands in large numbers to earn a living the government took the view that they should be given the opportunity to use the Dutch health service facilities. Those who hold valid work or residence permits have the same rights as the Dutch population. Even some categories of illegal immigrants may use the health services. For a guide to the various schemes and rights for this category of foreigners see the survey drawn up by a member of staff of the Health Insurance Funds Council at the request of the medical consultative body (Kragting, 1982).

The fact that in theory there are no barriers for the majority of migrants says nothing, however, about the practical accessibility of the health services to them or the quality of the care received. Some impression of the former could be gained from the use made of health service facilities, although it should be pointed out that this gives no indication of the desirable level of use.

In the next sections I shall consider the problems of investigating the use of facilities and the quality of the care.

Use of facilities

Information on the use of the facilities should be obtained from statistics collected systematically on numbers of consultations, numbers of referrals, use of medicines, etc. In this case it must, however, be possible to identify various sub-groups in the population. It emerges that neither the curative nor the social nor the industrial health care sector keep data of this kind (Hoolboom, 1982). There are apparently no systematically collected data within the curative sector on the use made of general practitioners by the various sub-populations. The health insurance funds' national records system (LISZ) contains data on hospital admissions and specialist treatment; personal data are however not recorded. The local health insurance funds refuse to record the nationality and place of birth of their members for reasons of principle.

Nor do the perinatal or juvenile health services keep systematic records of the use made of them by various categories of clients. All vaccinations are recorded on a personal basis (on a vaccination card); comparisons between various sub-groups are impossible since nationality is not stated in the records of the provincial immunisation authorities.

In recent years a growing number of employees have become entitled to industrial health care. So far data on the care provided to various categories of employees have been published only on an occasional basis. A recent survey (Hoolboom & Van Leeuwen, 1982) revealed that over 28% of the industrial medical services questioned could not provide statistics on the nationalities of the employees they had under care. Attention should be given to improving registration in this respect when the Working Conditions Act comes into force.

It is clear from the above that the absence of data on nationality is an additional obstacle to research into the use made of health service facilities by members of ethnic minorities. Information can only be obtained by instituting specific research projects.

Quality of the care

As stated at the beginning, allowance must be made for the frame of reference applied by the section of the population in question when assessing the quality of the care.

There is even a large group among the Dutch population which uses alternative forms of medicine to treat health complaints. Recent research gives an indication of the extent of this practice (Ooijendijk and others, 1980; Aakster, 1982). There are no statistics on the use made by members of ethnic minorities of their native forms of treatment, but this is not likely to be proportionately less than that of the Dutch population. From the point of view of the official health services consideration should also be given to the quality of the care provided to migrants.

In addition to indications of problems from the professional sector, from time to time there are similar reports from various minority groups (Hoolboom, 1981; Dorrenboom, 1982). Reports of misunderstandings between Dutch doctors and foreign patients, sometimes with unhappy outcomes, are also seen in the press.

Research among the migrants themselves seems to be the only way of obtaining information on their attitude to the care provided. A major obstacle here is the inaccessibility of the ethnic minorities: in many cases a direct approach will be made difficult by the social control exerted on the respondents by their immediate circle. Some professional helpers may also allow their judgement of the quality of the care and the facilities which they believe necessary to be influenced by their strong social and emotional involvement with the minorities. Careful evaluation of particular health service facilities could no doubt improve our understanding of the quality of the care provided. The recently concluded preliminary survey of Moroccan and Turkish babies and toddlers in the juvenile health service (Grundemann & Hoolboom, 1982) is a move in this direction.

Research into factors which affect the provision of care

Research into the use and quality of the care should take account of factors which might enable any improvements needed to be made. Any full survey of foreign babies and toddlers in the juvenile health service, for example, should give a great deal of consideration to the characteristics of both the section of the population receiving care (length of stay in the Netherlands, composition of family) and the clinic (size, methods, presence of special facilities).

In general, account should also be taken of the knowledge and skills of the professionals, and information should be obtained on their attitude towards immigrants. If the best possible care is to be provided they must be willing to try to understand the help-seekers.

Obstacles to research of this kind are presented not only by the inaccessibility of the section of the population involved but also by the difficulty of obtaining co-operation from the professionals, who are not only faced with an additional burden on top of their normal work but are also required to "let people into their kitchens".

Conclusion

Research into health and health care in ethnic minorities runs up against many difficulties. A major obstacle to using existing records systems for research into the health of ethnic minorities is the general absence of data on nationality. Nevertheless opportunities for research do exist in theory. It would no doubt be worthwhile to try, with government aid, to obtain the cooperation of, say, the Medical Registration Foundation and general practitioners to make foreign patients identifiable.

I have discussed the linking-up of statistics on deaths and causes of mortality above. The population data collected by the municipalities could be used to establish the nationality of deceased persons: research could then be carried out into causes of mortality in ethnic minorities, although illegal immigrants and naturalised nationals would not be included.

When investigating experienced health and psycho-social problems by means of questionnaires and interviews, consideration should be given to the validity of the research methods used and the way the respondents are approached. Use of Dutch interviewers with a knowledge of the migrants' language and background would appear to be an attractive way of tackling the problem of approaching the respondents.

As regards individual medical examinations, the aim should be to reach a definition of medical diagnosis which can be used in comparisons between groups. A problem-oriented form of medical record designed especially for migrants should be drawn up in consultation with experts on the cultural backgrounds of allochthones. The quality of the health data collected in the various areas of preventive health care should be improved if they are to be used to detect differences between the health of Dutch and immigrants.

A control group must be available before research can take place into the factors which affect migrants' health. In many cases great difficulty will be encountered when trying to put together representative sample and control groups because of the absence of specific demographic data. The cooperation of the municipal Population Departments is essential if the necessary information is to be obtained. Research into the way the health services operate in relation to members of ethnic minorities is hampered first of all by the absence of systematic data on the care provided. Registration of nationality or place of birth is sometimes avoided for reasons of principle. This is no doubt due partly to fear that some link-up of data between the health services and other administrative systems could harm the interests of individuals. Consequently both the use and quality of the care need to be investigated by means of specific research projects. Obstacles to this are (a) the inaccessibility of the ethnic minorities and (b) the difficulty of obtaining the cooperation of some professional helpers.

A special word should be said about research into foreigners residing in the Netherlands illegally. Because they are not registered, they are extremely difficult to find as a group. Information on their health can probably be obtained only by means of ad hoc observations. This is not to say, however, that the health of certain groups is not in danger, for instance owing to the nature of their work. Any damage to their health which does not become manifest until some time later would not be noticed until they had returned to their home country. It might well be possible in certain cases to find foreigners in their village communities in order to establish whether they have suffered any damage to their health. This would enable cases of occupational diseases to be identified. This, however, is only part of the problem I have outlined. Above all, researchers investigating health and health care in ethnic minorities must remember that Dutch and immigrants may attach different meanings to the concept of illness and define it according to their own frames of reference; consequently the concept of quality can have a different meaning for the two groups. Proper cooperation between health care researchers and experts on migrants' cultural backgrounds is also needed for research of this kind.

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PART III

HEALTH CARE RESEARCH AND EVALUATION FROM THE COUNTRY OF ORIGIN: TURKEY AND MOROCCO

INTRODUCTION TO HEALTH CARE RESEARCH AND EVALUATION FROM THE COUNTRY OF ORIGIN: TURKEY AND MOROCCO

M. Colledge and
P-G. Svensson

In the previous section the response to health care delivery and research from the point of view of the recipient country has been dealt with. What has often been ignored by reseachers and policy makers has been the initiatives of the country of origin to its outgoing citizens and the facilities that need to be provided when they return to their homeland. Oztek traces the problems of the Turkish women against the background of mass migration in Europe, noting the impact on the public health of children and adults, while Nejmi looks at the practical response of Moroccan agencies to its citizens working in Europe, expressing the policies that have been adopted, and those that could be implemented to reduce the difficulties faced by the Moroccan worker. Both authors bring to our attention the need to evaluate migrants' health against the difficulties they have to face adapting to the host countries' cultural and political structures, and how they have to come to terms with the educational and bureaucratic structures of the state. The temporary nature of their status position reduces migrants to being marginal members of society and prevents them from making stable relationships with the host population. It is also clear that there is a crisis of identity, a pull between the cultures which leads to alienation and often distress. It is clear that one of the major factors for health care policy is the position of second generation migrants, and the difficulties of adaptation, being caught within the influence of two cultures. Also policies for adaptation have to be sensitive to the needs of migrant women. Oztek and Nejmi in their chapters draw on the importance of developing means of communication which allow for the imbalance of separation and uncertainty which dogs the migrants' lifestyle.

CHAPTER VI

SOCIAL AND HEALTH PROBLEMS OF MIGRANT WORKERS

Z. Oztek

One of the most important social events of our time is the mass migration of workers from developing countries to northern and central Europe. This migration does not only have economic and political outcomes, but also creates some problems related to the social life and health conditions of the foreigners in Europe. There is no doubt that the problems facing the migrant workers also affect their working life.

Large scale international labour migration has created perhaps the most significant social event of the century for Turkey. Nearly one million Turkish labourers have gone to work abroad since the early 1960s. One-fourth of the foreign labourer population in some of the host countries is comprised of Turks and in Turkey a large number of workers are waiting in line in order to find jobs abroad. The significance of the matter has led to the establishment of special departments within the Ministries of Labour, Foreign Affairs, and Education of Turkey dealing exclusively with matters concerning Turkish migrant workers. Similar organizations have also been established by many of the host countries due to the important extent to which their industries depend upon foreign workers.

A number of social workers of different nationalities in Stuttgart were contacted and asked what they regarded to be the most important problems of the migrant workers. According to the Italian and Turkish social workers, the most important problem of these two ethnic groups was the language barrier (1). The survey done by Oztek in Berlin (West) revealed that the level of knowledge of the

German language among 36.2% of the Turkish workers as insufficient to do their work properly (2). Of the workers, 61.1% stated that they could not communicate with the German doctors because of their poor knowledge of German (Table 1).

No doubt one of the most depressing facts which affect the migrant is the attitude of the native people against them. The migrant workers have been accepted merely as a labour force by the institutions they are working for. Berger and Mohr (3) stated this fact very obviously in one of their publications:

> "Only a minority of workers are permitted to settle permanently in the country to which they have come. The migrant worker comes to sell his labour power, where there is a labour shortage. He is admitted to do a certain kind of job. He has no rights, claims or realities outside filling that job. If he no longer does so, he is sent back to where he came from. It is not men who immigrate, but machine minders, sweepers, diggers, cement mixers, cleaners, drillers, etc. This is the significance of temporary migration. To re-become a man (husband, father, citizen, patriot) a migrant has to return home. The home he left because it held no future for him."

This may appear to be exagerated, but there is no doubt that it reflects a fact. Just one evidence of this fact is that the migrant workers are able to bring their wives and children to form their family unit only after a certain period of time and after many hardships. It is accepted by many authors that there is a saturation point which the native population can accept in relation to the foreign population. It was stated in a World Health Organization meeting that the difficulties are often accentuated by an atmosphere of rejection by the host

Table 1: Level of knowledge of the German language among male Turkish workers living in Berlin (West)

(Percentage distribution)

	Insufficient	Fair	Good
During marketing	32.2	54.2	13.6
In work places	36.2	50.5	13.3
In restaurants	43.5	44.2	12.3
Communication with doctors	61.1	29.5	10.4
Reading newspapers	88.0	7.7	4.3

Table 2: Persons responsible for the care of the migrants' children living in Berlin (West)

Responsible person	Age groups				Total	
	0 - 4		5 - 14			
	No	%	No	%	No	%
Mother	140	56.2	175	39.7	315	45.7
Father	5	2.0	9	2.0	14	2.0
Relative	23	9.2	27	6.1	50	7.2
Neighbour (Turk)	34	13.7	14	3.2	48	7.0
Neighbour (German)	5	2.0	4	0.9	9	1.3
Day care centre	28	11.3	16	3.6	44	6.4
Siblings/Themselves	14	5.6	196	44.5	210	30.4
TOTAL	249	100	441	100	690	100

population, especially when the percentage of migrants in a community rises above 10% to 12% (4).

The mass migration in ten or fifteen years, which is a relatively short period of time, has caused the problem to reach saturation point and to start the reactions of the host population against foreigners. An important part of the native population of the host countries sees the immigrants as members of a low social class and a group which makes them uncomfortable. A British author has described the migrant workers as "invaders" and "a group of people who take the jobs of the native population". On the other hand, a Turkish author called the migrant workers "the Negroes of Europe" (1).

The reactions of the native population towards the foreigners, who are already faced with difficult adaptation problems to their new environments, forced them to concentrate in ghettos. The longer foreign workers stay in an area, the more they are forced to congregate together (5).

Since the main factor in labour migration is economic, the migrants tend to earn and save as much money as they can. This basic factor forces them to minimise their living conditions. So they reduce their food, minimise their housing conditions and sacrifice their social needs in order to save as much as possible. The greatest sacrifice on their side is that they have come to live in a very different culture from their own, leaving the rest of their families back in their home countries.

It is apparent that such a constant and prominent social phenomenon as international labour migration leads to other social issues, the primary ones being the question of family unity and problems related to the children of migrant workers. It is a well known fact that more children and other members of the family are left behind than are taken abroad. Results of a survey conducted by the Turkish State of Planning Organization in 1971 reveal that 76% of the Turkish workers who went abroad left their wives and children behind (6).

A great majority of migrants consider their children a "lost generation". There are important reasons which cause such despair for these parents.

Child care is the biggest problem in relation to the children of migrant workers. A survey done in Berlin (West) showed that 57% of Turkish children below 15 years of age were taken care of by people other than their mothers. A more important finding was that nearly 20% of the children in the pre-school age group (5 to 6 years) were looked after by siblings who were not much older than themselves. In the same survey(2), it was also found that 52% of the children between 7 and 14 years of age took care of themselves (Table 2).

It is very interesting that in the Berlin (West) survey, 24% per cent of the Turkish children between 5 and 14 years were found to be malnourished. This rate was significantly higher than the rate among the same age group living in Turkey. However, Dr. Aksu (7) showed that the dietary habits of the workers in Federal Germany have considerably changed. The type of food consumed most frequently and in higher quantities has changed from cereal based to animal origin foods. However, the meals prepared still have the same characteristics as typical Turkish dishes. Although the Turkish migrant families in Germany get 40% of their protein requirements from animal source protein, the expected increment in energy intake was not observed. (Tables 3, 4).

Psychiatric symptoms were also found to be significantly higher in the Berlin (West) study group than in the control group children in Turkey as regards stuttering, nail biting,

Table 3: Malnourished Turkish migrant children.

(Percentage distribution)

Groups	Age groups			Total
	0 - 4	5 - 14	15 - 18	
Berlin (West)	8.5	24.1	18.3	18.4
Control (Turkey)	8.2	15.4	17.2	12.6
p	>0.05	<0.05	>0.05	>0.05

Table 4: Average consumption of nutrients and energy.

(Consumer unit/day)

	Control (in Turkey)	Migrants' families left in Turkey	Migrants in in Berlin (West)
Energy (KCal)	2968	2810	3110
Protein (Gm)	96.3	98.6	104.8
Animal source protein	19.6	20.4	40.2

and thumb sucking (2). The higher rate of some psychiatric symptoms and the higher malnutrition rates, especially among the 5 to 14 year age group, in the Berlin (West) study group of children as compared to the control children in Turkey, can be attributed to the insufficient child care of the Turkish migrant workers' children abroad.

At present, it is estimated that there are three million women over 18 years of age among the foreign population in Europe. The majority of these women still work or have worked for some time in the past. Without doubt, the reason for this is economic. As a matter of fact, a survey done by the State Planning Office of Turkey, showed that most of the male workers desired their wives to work. 7% of the husbands who did not want their wives to work gave as the reason for their attitude the unhealthiness of the working women.

It is true that working women lose their health more than the men do. The fact that women also work at home is the additional factor in this. This is more apparent in the Turkish families where the traditional roles of the husband and wife still exist. Oztek (2) confirmed that the working Turkish women in Berlin (West) showed more psycho-somatic symptoms than those who did not work. This fact is more evident for women who have lived more than four years away from their home countries.

The same thing is true for wives who have been left at home. It has been shown in sveral studies that this group complains of psycho-somatic illnesses significantly more than the normal population. In a study carried out in Turkey (8) it was shown that wives left in Turkey apply to physicians almost twice as often as before. This rate considerably increases after three years of separation of the couples. (Tables 5, 6).

Table 5: Applications of the wives left in Turkey to health centres.

Duration of separation	Yearly average application
1st year	1.5 + 0.3
2nd year	1.5 + 0.4
3rd year	1.4 + 0.3
4th year	1.8 + 0.6
5th year	1.8 + 0.5
6th year	2.2 + 0.4
7th year	2.4 + 1.7

(Figures for control group are between 0.9 and 1.4.)

Table 6: Psychosomatic complaints among the migrants' wives left in Turkey.

Type of complaints	Migrants' wives		Control		p
	N	With complaint %	N	With complaint %	
Headache	187	77.5	214	68.8	< 0.01
Neck ache	187	57.2	214	34.6	< 0.01
Depressed feeling	187	74.3	214	57.5	< 0.01
Stomach ache	187	50.3	214	45.8	> 0.05

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CHAPTER VII: SOCIAL AND HEALTH CARE OF MOROCCAN WORKERS IN EUROPE

Slimane Nejmi

Economic growth in Europe during the 1960s and 1970s led to the mass migration of workers from the Mediterranean to provide the necessary labour force to meet the industrial objectives of the time.

On the eve of the 1973 economic crisis, Moroccan workers could be found living in most European countries. This Moroccan colony reached a total of 703,000 people distributed as follows (see Table 1).

(1) Characteristics of Migrant Workers in Europe

Unlike Italians and Spanish migrants whose age varies between 30 to 45 years, the majority of migrants from Morocco are young (aged 18 to 25). See Table 2. More than 50% are under the age of 35 years. Most of these Moroccans are recruited into unskilled jobs in the host countries, and have been seen as a valuable and reliable source of labour.

Because of the marginal position of these workers in some European countries one of the major problems has been in the housing and lodging position of the migrants.

Moroccan in-patients interviewed in a number of hospitals in France about their housing conditions, revealed the following:

Table 1: Moroccan migrant workers in Europe.

Country	Total (thousands)
France	420
Belgium	107
Germany	40
Netherland	73
Spain	30
United Kingdom	15
Italy	15
Scandanavia	3
TOTAL	703

Table 2: Age distribution of Moroccan migrants.

Years	%
16 - 20	2.3
20 - 25	13.1
25 - 30	22.0
30 - 35	17.2
35 - 40	15.1
40 - 45	11.2
≥ 45	17.1

- 54% declared they lived in ordinary conditions
- 46% declared that they lived in unhealthy houses.

Types of accommodation were broken down as follows:

- 45% live in a furnished hotel
- 20% live in shanty towns
- 20% live in transit buildings
- 15% live in crumbling houses.

Lack of adequate suitable accommodation with bad sanitation and over-crowding means stuffy rooms, too small for a group of workers who can't afford to rent a decent house, etc., which lead to the dangers of overcrowding and outbreaks of diseases such as tuberculosis, diarrhoea, dermatosis.

(2) Moroccan Women in Europe

The migration of Moroccan women has been steadily increasing in the last decade. About 120,000 migrant women live in Europe; 85% are not literate. Generally we find three groups of Moroccan women who can be categorised by their basic linguistic skills:

(a) Traditional women who don't speak the language of the recipient country. They form a marginal group and live in the shanty towns.

(b) Women who have a basic grasp of the language of the recipient country. They tend to live in group housing or in old and condemned housing.

(c) Women who speak the language of the recipent country. They generally have well paid jobs. Most of them were either born in the recipient country or came to it at an early age.

Migrant women carry the additional burdens of family obligations, and may be having to work in mechanised organisations but still have to retain their cultural identity.

(3) Migrant Youth

Migrant youth come under three basic categories:

(a) Children born in their country of origin: generally they speak their mother tongue and a little of the language of the recipient country.

(b) Children born in the host country: they speak the host language with skill

(c) Children born from mixed marriages: this group very often is socialised into using the host's language.

General problems of adjustment arise for young people in all three categories. First there are the problems of adaptation and coping with two cultural frames of reference. Conflicts may occur between what is taught at school, on the street and by means of some recreational activities in the recipient countries, and the parents' traditional Moroccan upbringing. Secondly, poverty, bad housing, lack of adaptation to the way of life, all this leads them to feel stifled and frustrated. The lack of money obliges the migrant children to spend most of their leisure time in boredom, idleness and they end up, very often, being delinquent. This delinquency concerns a majority of migrant children in Europe. One third of offenders are less than 25 years old. Collective delinquency in the forming of gangs has been seen recently.

Due to alienation in a foreign society many young Moroccans have no choice left but to return home. There is a risk that they will form a vulnerable group back in their homeland. For those who returned we analysed the consequences and from these we deduced the following

(4) Proposals for Action to Meet the Health Needs of Moroccans

We have already seen the majority of problems encountered by the Moroccan workers in Europe, especially related to health care, language, social relationships, culture, education, adaptation. Efforts from the origin country, host country and migrants themselves should be brought together towards reducing and later getting rid of the influence of the aforementioned problems affecting health and well-being.

(a) Moroccan role in assisting its migrant colony in foreign countries

The Moroccan government conscious of the hard conditions in which its workers live, has given particular attention to the problems caused by migration.

In order to bring these conditions to an end, it has been decided to implement the following:

(1) Creation of a pre-immigration centre in Casablanca.

(2) Appointment of social attachés in Europe.

(3) Reception office at ports and airports in Morocco.

(4) Sending of teachers to Europe.

(5) Agreements concerning social security.

(6) Appointment of employees from the Ministry of Justice.

(7) Holiday centres in Morocco.

(b) A pre-immigration centre has been created in Casablanca

The centre has been set up to brief the migrant workers and their families on aspects of life in Europe, on their obligations, their rights as migrant workers and their rights to health and social protection.

In this centre there is a team sent by the Ministry of Health, whose duties are to make sure that each migrant is correctly vaccinated and each migrant possesses a medical record card.

(c) Appointment of social attachés in consulates and embassies

These attachés will help Moroccan migrants to deal with official requirements of migration such as birth certificates, passports, citizenship certificates, news from the family, etc... (see Table 3).

(d) Reception offices

They have been met at ports, airports and frontiers in order to help them fill in forms for customs and police. Close to these reception offices there are dispensaries with qualified nurses for emergency care.

(e) Social security

The Moroccan government is aware of the importance of the social security role, in favour of peace and stability of the worker and his family. This is why it has given prior importance to reaching agreement on social security with the main importing countries of our labour workers. Particularly these agreements cover sickness insurance, invalidity insurance, elderly insurance, widows and orphans insurance, redundancy insurance and family allowances.

(f) Mother tongue

The teaching of the mother tongue helps the child to keep in touch with his country of origin and to minimise the effects of the shock

Table 3: Social attachés in Europe.

Country	Total
France	11
Belgium	3
Germany	3
Spain	2
Netherlands	2
Scandanavia	1
TOTAL	22

Table 4: Moroccan teachers in Europe.

Country	Teacher	Inspector	Total
France	92	-	92
Belgium	60	2	62
Germany	10	-	10
Netherlands	11	-	11
Spain	3	-	3
Scandanavia	1	-	1
TOTAL	117	2	179

caused by a sudden and eventual returning back home. In order to achieve this the Moroccan government has appointed teachers to be sent abroad in different host countries to coordinate in the field of education concerning Moroccan children (see Table 4).

(g) Because of the steady increase in the family groups in the last decade in Europe, it has become necessary to provide Moroccan workers with a certain number of employees from the Ministry of Justice to solve the matrimonial problems.

(h) **Holiday centres in Morocco**

These centres have received so far 2,000 Moroccan children and children of different nationalities from host countries. They enjoy themselves together in these holiday centres. At the same time, they learn about the social realities, habits and customs of Morocco. The results of this experience are encouraging.

(i) **Friendship associations in the host country**

It is important to note that Moroccan migrant workers have helped themselves in that men and women have formed their own friendship associations. These associations have been set up according to regulations of the host country.

(1) **The role ot the men's association is:**

- to assist the Moroccan migrant and his family in their efforts towards adaptation to the social and economical surroundings of the host country;

- to assist the illiterate and semi-literate workers in understanding jargon of the forms and administrative procedures of the host country;

- to organise the leisure time with social and cultural activities, artistic and sport activities plus religious talks;

- to make European public opinion aware of the problems encountered by Moroccan workers, so that hopefully, Europeans will be persuaded to accept the migrants and help them to adjust to the daily way of life. These friendship associations are under the control of the Federation Friendship Association.

(2) **The role of the women's friendship association is**

- to arrange meetings to deal with womens' issues;

- to organise conferences and project films in connection with the country of origin;
- to provide women with social educational courses.

CONCLUSION

There are about 703,000 Moroccan workers in different European countries. These workers contribute to the economic growth of these countries. More than fifty per cent of these workers are young (age 18-25) and work in different sectors of activities such as metallurgy and construction.

(1) Among the problems encountered by Moroccan workers, the most acute ones are the following:

- Living far away from one's family (this has an effect on the psychological and spiritual well-being of the workers).
- Bad housing conditions (this is a source of tuberculosis; dermatosis).
- Absence of adequate leisure (sports, cultural films, skiing holiday).
- Social isolation (originating from the language, behaviour, culture, style of life, etc.)

All this inevitably leads the worker towards boredom, idleness and a loss of his sense of identity, self-esteem and well-being.

(2) 120,000 migrant Moroccan women live in Europe, 85% are illiterate and overwhelmed by family obligations, facing many problems (difficulty of expression in the foreign language, working hard to save her sense of cultural identity).

(3) Considering the important role played by migrant workers in the economic growth of European countries and according to the strategic aim of the World Health Organization, in order to obtain health for all by the year 2,000, one of our major duties is to plan a programme of assistance to migrant workers in Europe.

This programme should be planned in common by the country of origin, the host country, the migrant themselves and by the international organizations (U.N., W.H.O., U.N.I.C.E.F., U.N.E.S.C.O., and U.N.R.W.A.).

PART IV

ASPECTS OF HEALTH CARE INTERVENTION IN HOST COUNTRIES

ASPECTS OF HEALTH CARE INTERVENTION IN HOST COUNTRIES

M. Colledge and
P-G. Svensson

Introduction

After debating theoretical, political and policy formulations we turn in this section to some of the practical initiatives that are being evaluated in some European countries. In general terms des Fontaines describes how a private agency in France acting as a pressure group outlines and develops a programme that advocates for migrants' health. Donnay, Dal and Thoss's contributions focus on family planning and the initiatives that follow from the World Health Organization study on migrants and their special needs in relation to sexuality and family planning. Broekx has been responsible for initiating health education literature for migrants in the Netherlands, and some examples of his agency' work are illustrated in this section. Psycho-social problems and mental health are expressed by Simoes reporting on recent research followed by Alma who gives a social worker's review of the stresses migrants face and the strategies for help.

The contributions in this section highlight the problems of cultural adaptation that have been dealt with earlier. Donnay and Thoss draw the attention to the need for domiciliary visits, so that the health workers can see how ethnic groups dealt with health issues within the family. Broekx's paper on information materials for migrants and health workers underlines the importance of communication and feedback, and that publishing for migrants should not be seen in isolation, but rather for locating information and educational programmes as complete packages.

The central issue emerging from the experiences outlined in this chapter is the language barrier, which if not dealt with effectively can block any initiatives for health education. Language and an ethnographic knowledge base of the migrants' cultural ways of living are the keys that unlock the barriers created by misunderstanding and misinterpretation. Sachs' and Spruit's earlier chapters outline this change and give the practitioner a model from which they can operate.

Simoes looking at the mental health of migrants stresses the importance of not mistaking illness for problems of living and the reality of shock of migration, based on the research carried out and the methodological problems that emerge.

Alma taking a pragmatic view outlines a typology of psycho-social problems for migrant men and women. Alma's final research quotes a book by Fuglesang summing up the wide purpose of this section and possibly the whole book:

"Why do you, white person, not try to understand the minds of Africans more than their ability to work? You people do not understand your words do not belong to our minds."

CHAPTER VIII ADVOCATING FOR MIGRANTS HEALTH

Virginie des Fontaines

Numerous agencies deal in France with migrants' social conditions, but very few include health issues among their objectives. This issue raises several questions:

- is it possible to point out specific health problems regarding migrants' condition?
- if yes, which specific questions should be asked, that is to say should we develop specialised services to deal with their needs?
- if not, should we pay a specific attention to migrants' health, as an exposed group, with the risk of stressing differences?

It is against the background of these questions that the Comite Medico-Social pour la Sante des Migrants (CMSSM)* formalised the following objectives:

(a) to collect all documents relevant to migrants' health issues

(b) to point out priorities and set out plans for action

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* Medico-Social Committee for Migrants' Health

Address: CMSSM
23 rue des Louvre, 75001, Paris.

(c) to provide the migrants and their families with informations on their rights and the means of access to health facilities

(d) to inform and to train health professionals in the field of the risk exposure of the migrant population

(e) to act as an advocacy group in front of public authorities in order to favour the development of adequate health policy

The C.M.S.S.M. Activities (1982 - 1983)

The Committee has three main areas of activity: information, training and special programmes.

- In the field of **information**, our pedagogical materials have now been evaluated for health education use and made available for field workers in migrant communities.

  The topics are chosen by the users and deal with health education issues such as: "getting to know your body", "sexology, pregnancy, birth and infancy", "tuberculosis", "shistosomiasis" etc... These documents which are unfortunately only available in French are specially designed for non-literate audiences. A number of films have been produced: an example is a film explaining an encounter between an Algerian worker and a practitioner (summary available in French). The title of this film is "I cannot tell ..." and the general topic is about communication.

  Another film is about main health problems among migrants and a third one deals with migrant women's perceptions of pregnancy and birth.

- **Training:** several programmes are now in operation:

(1) A full course in a medical school at a post-graduate level (Faculte de medecine de la Pitie - PARIS, 35 hours). The main issues dealt with are: migration processes, health and culture, health and labour, the relationship between sick migrants and health professionals and the needs of the second generation of migrants.

(2) Several short sessions aimed at maternal and child health workers, nurses, social workers, health planners. Addressing practical concerns and reflection on cultural adaption of migrants to the host population.

(3) Training in hospitals for hospitalised migrants: three hospitals have experimented with two-fold programmes; firstly in teaching the basics of the french language to overcome the difficulties for the patients when they have completed the necessary administrative forms; secondly, to develop good patient/professional communication to overcome the language barrier and different culture perceptions of health.

(4) Direct training of migrants: basic training for small informal groups of for example, African women, so they will be able to practise health education in their neighbourhood.

Several **specific programmes** have been developed to address a number of issues:

(1) A programme which pertains more to ethnological field than health field adresses the question of "sexual mutilation". Evidence has

been collected and a report prepared for circulation to health professionals and legislators.

(2) A research programme experiencing ethnic nutrition has begun in order to provide our national educational health programmes with a background to the national problems of migrants.

(3) A research group has been formed to explore the risks of accidents at work and their consequences to migrants. The new objective is to get the public authorities to change legislation so that the migrant workers' rights are upheld.

(4) One of the problems of the second generation of migrants is failure to adapt to schooling, with consequences for mental health. Support proposals are being prepared to attempt to assist in cultural adaptation.

(5) The Committee has been given the responsibility for the care of South Asian refugees. They are migrants too, but their health status is closely linked to their life condition during the immediate period before their arrival in France. Worms, tuberculosis, have to be cured during the first weeks of their stay. To this end, several screening procedures and therapeutic programmes dealt with their needs.

(6) The problem of illegal workers has increased. Since the summer of 1983, the government has decided to exclude from French territory any worker who does not have an official working

permit. Unfortunately, these migrants are usually those who have the worst health status and tuberculosis rates are especially high in this group. Pilot studies demonstrate that some care can be provided at an unofficial level.

(7) One of the Committee's objectives has been to communicate with the agencies in other European centres to share their experiences, and exchange materials. Also to explore the possibility of developing a new European federal agency.

From this overview of our committee's activities, it can be seen that the organisation of health care to allow for greater accessibily for migrants, including those who due to new legislation have marginal legal status, has been advanced.

Attempts have been made to look at the integration of preventive and curative medical initiatives with films, etc. French regular health structures have never integrated preventive and curative services except in the field of occupational health, and this is true only in some factories and in the field of mental health at community level.

More emphasis is needed to explore folk medicine in France although ethnopsychiatry is on the increase, and there is cooperation with folk healers.

Finally, the Committee will be addressing special health needs, as 50% to 60% of migrants' children are born in France and this is a matter of concern for researchers, educational and health planners. School failures and maladjustments lead to a lack of qual-ification and poor job prospects or unemployment.

281 166

CHAPTER IX MIGRANTS AND THEIR SPECIAL NEEDS IN RELATION TO SEXUALITY AND FAMILY PLANNING IN BELGIUM

France Donnay and
Martine Dal

Some preliminary comments will be made but a final report has been issued by World Health Organization based on the work of Donnay and Thoss.

This is the area explored in a study initiated by Ms W. Haddad, Family Planning Unit, Regional Office for Europe, World Health Organization.

Objectives

Since 1965 there has been an important migration flow from all regions of Morocco to Belgium and the society which has emerged is composed of populations with very different cultural traditions. They have different, and even opposite behavioural norms regarding family planning and sexual education in particular. Besides, the migration process itself has a strong impact on the attitude towards fertility and sexuality.

The approach was to survey the activities at a family planning centre in a populous area of Brussels with a large immigrant population, essentially of Moroccan and Turkish origin.

First we gave immigrant women the opportunity to talk about themselves by conducting interviews on the basis of a "response pattern". The information gathered provided the material for an analysis which seems to us quite worthwhile, in spite of being qualitative rather than quantitative.

Then we made a critical assessment of the activity of the centre to ascertain in particular to what extent it enables the free expression of the dynamics which emerged from the discussions we had with migrant women.

Finally, the exploration initiated by these interviews and the anlaysis of a medical, psychological and social experience led us to question the concept of needs and the services that should be available.

The findings have been used as the basis for the provision of family planning to meet migrant needs in Belgium.

Reference

Aspects of family planning and migration, Dr. F. Donnoy and Ms E. Thoss WHO Regional Office for Europe ICP/MCH504/s01, 1985.

MIGRANTS AND THEIR SPECIAL NEEDS IN RELATION TO SEXUALITY AND FAMILY PLANNING IN THE FEDERAL REPUBLIC OF GERMANY

Elke Thoss

Social services for migrants in the Federal Republic of Germany are mainly provided by 600 counselling centres which are run by the social institutions of the Catholic and Protestant churches and the Arbeiterwohlfahrt (AWO), an old social welfare organisation historically deriving from the German workers' movement. The latter provides assistance to more than 50% of the migrants living in the Federal Republic of Germany: Turkish, Yugoslav, Tunisian and Moroccan migrants and their families.

The counselling centres employ about 250 social workers from donor countries. They mainly deal with work and housing problems of the migrants and do not provide family planning services.

At the moment **PRO FAMILIA** is the only organisation which offers the migrants services concerning family planning, sexuality and partnership questions.

PRO FAMILIA did not take the initiative with regard to migrants. It was as a consequence of the liberalisation of the abortion law in 1976 which made abortion counselling obligatory, that **PRO FAMILIA** was confronted with a new group of clients - migrants from other European countries. In 1979 more than 16% of all clients were from foreign countries, principally Italy, Yugoslavia, Spain, Greece and Portugal.

When **PRO FAMILIA** was suddenly confronted with large numbers of migrant clients, it was not ready to cope with the needs of its new target group. The first phase of migrant counselling was therefore characterised by adhoc reactions and **PRO FAMILIA** tried to counsel as well as possible with the help of interpreters.

Reference: This study is reported in full in

Aspects of family planning and migration, Dr. F. Donnoy and Ms E. Thoss WHO Regional Office for Europe ICP/MCH504/s01, 1985.

CHAPTER X HEALTH CARE AND EDUCATION AIDS FOR FOREIGNERS IN THE NETHERLANDS - SOME EXAMPLES

M. Colledge, P-G. Svensson and G. Broekx

We felt it appropriate at this point to show examples of material prepared by the Office for Information on Health Care for Foreigners to improve the contact between workers in health care and their Turkish, Moroccan and Spanish patients.

Aids have been prepared in the following areas

- Obstetrics
- Maternity Care
- Infant Welfare
- Dietary Information
- Family Planning
- Mental Health Care
- Oral Hygiene.

Some of these examples with reference to oral hygiene, maternity care and obstetrics are shown overleaf. The office has developed materials for several subjects, consisting of:

1) brochures, intended for the workers in health care, students. They try to give concise background information, relevant to several fields like maternity care, family planning, etc.;

2) lists of key words in Turkish-Dutch or Moroccan-Dutch, relevant for workers in intramural health care, dentists and oral hygienists, etc.;

3) a series of communication themes, intended for the patients with information reinforced by drawings, with the text in Turkish-Dutch or Moroccan-Dutch (N.B. Moroccan must be read from right to left.); and

4) a survey of audio-visual materials that can be used in group-education. This survey contains video-tapes about the following subjects: "Migrant children in hospital", "Psychosomatic complaints of migrant women", "Diarrhoea in babies" etc.

It also contains posters about prenatal and maternity care, the skeleton etc.

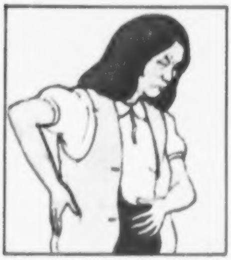
Broekx pointed out during the meeting, that the philosophy that lies behind the preparation is to facilitate a two-way process which allows the health workers to cross cultural and language barriers and gives the migrant some say in the health education agenda.

Other packages have been developed by the Office and details are available from this address:

Office for Information on Health Care for Migrants,
Postbas 100,
3980 cc Bunnik,
The Netherlands.

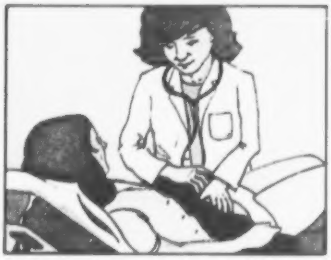
Gebelik şikâyetleri

ZWANGERSCHAPSKLACHTEN



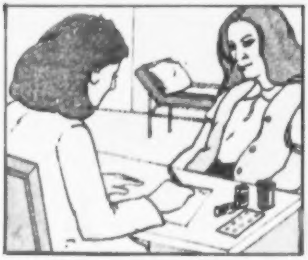
Gebe kadının vücudunda pek çok değişiklikler olmaktadır. Bu değişiklikler çok zaman can sıkıcıdır. Fakat, bunların çoğu zararsız ve normaldir.

In het lichaam van een zwangere vrouw verandert veel. Deze veranderingen zijn lastig. Maar meestal zijn ze normaal.



Şikâyetlerinizi, ebeye ya da ev doktorunuza anlatınız.
O sizi araştırır.

Vertel uw klachten aan de verloskundige of huisarts.
Zij onderzoekt u.

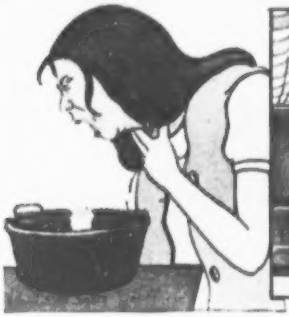


Doktor ilâç yazarsa, sadece o zaman ilâç kullanınız.

Gebruik alleen medicijnen als de arts ze voorschrijft.

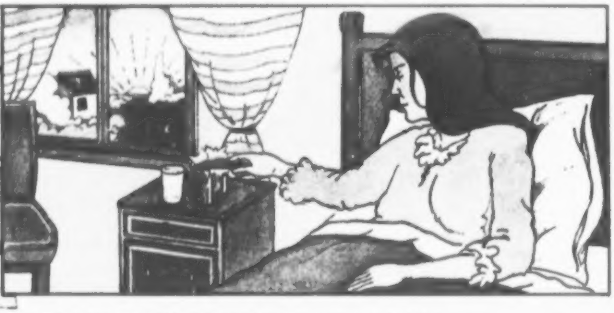
AŞAĞIDAKİ ŞİKÂYETLER SIK GÖRÜLÜR; (Bunların çoğu ilk üç aydan sonra kaybolur)

De volgende klachten komen veel voor: (ze verdwijnen meestal na de eerste drie maanden)



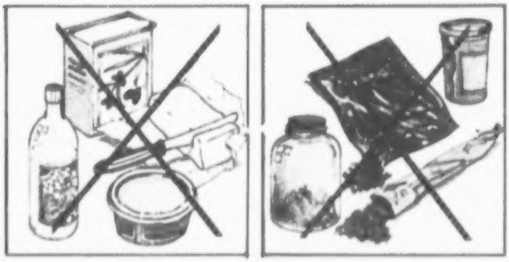
MİDE BULANTISI

Misselijk.



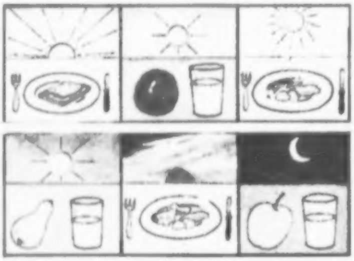
Yataktan kalkmadan önce biraz bir şeyler yiyip içiniz.

Drink en eet een beetje voordat u opstaat uit bed.



Donmuş yağ, zeytin yağı, tereyağ ve margarini, az kullanınız.
Acı baharat yemeyiniz.

Gebruik weinig vet, olie, boter, margarine.
Eet geen scherpe kruiden.



Her gün sık sık fakat biraz yemek yiyiniz.

Eet meer malen per dag.
Eet iedere keer een klein beetje.

Met deze woordjes kunt u de boodschap op blz. 1 uitleggen

nederlands	turkse uitspraak	turks
zwanger?	*ha-mie-lè-mie-sie-niez?*	hamilemisiniz?
problemen?	*pro-blèm-mie wàr?*	problemmi var?
ga naar de dokter	*dok-to-ra gie-dien*	doktora gidin
ga naar de verloskundige	*è-bè-jè gie-dien*	ebeye gidin
voor controle	*kon-trol ie-tsjien*	kontrol için
alstublieft	*luuit-fèn*	lütfen
ga liggen	*oe-zà-nùn*	uzanın
ik zal u controleren	*bèn kon-trol jà-pà-dzjà-ùm*	ben kontrol yapacağım
normaal	*nor-màl*	normal
andere medicijnen	*bàsj-kà ie-làtsj*	başka ilaç
niet goed	*ie-jie dè-iel/jòk*	iyi değil/yok

misselijk?	*mie-dè-niez-mie boe-là-nù-jòr?*	midenizmi bulanıyor?
's morgens	*sà-bàh-là-rù*	sabahları
biscuitje	*bies-kuu-wie*	bisküvi
u moet eten	*jie-jien*	yiyin

vet/olie	*jàh*	yağ
boter	*tè-rè-jàh*	tereyağ
kruiden	*bà-hà-ràt*	baharat
niet goed	*ie-jie dè-iel/jòk*	iyi değil/yok
elke dag	*her guun*	her gün
beetje	*bie-raz*	biraz
maar	*fà-kàt*	fakat
vaak (veel keren)	*sùk sùk*	sık sık
eten	*jie-jien*	yiyin

Met deze woordjes kunt u de boodschap op blz. 2 uitleggen

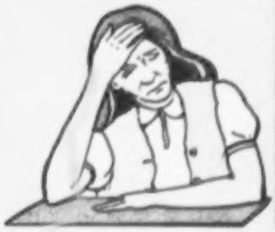
nederlands	turkse uitspraak	turks
hoofdpijn?	*bàsj àh-rù-sù-mù wàr?*	**baş ağrısımı var?**
moe?	*jòr-goen-moe-soe-noez?*	**yorgunmusunuz?**
's middags	*euh-lèn*	**öğlen**
slapen	*oe-joe-joen*	**uyuyun**
eerst	*eun-dzjè*	**önce**
warme melk	*sù-dzjàk suut*	**sıcak süt**
drinken	*ie-tsjien*	**için**
daarna	*sòn-rà*	**sonra**
's avonds	*àk-sjàm*	**akşam**
vroeg	*èr-kèn*	**erken**
slapen	*oe-joe-joen*	**uyuyun**

---

duizelig?	*bàsj deun-mè-sie*	**baş dönmesi**
flauwvallen?	*bà-jùl-mà-mù wàr?*	**bayılmamı var?**
lange tijd	*oe-zoen zà-màn*	**uzun zaman**
staan	*à-jàk-tà doer-màk*	**ayakta durmak**
niet goed	*ie-jie dè-iel/jòk*	**iyi değil/yok**
zitten	*ò-toe-roen*	**oturun**
frisse lucht	*tè-miez hà-wà*	**temiz hava**
goed	*ie-jie*	**iyi**

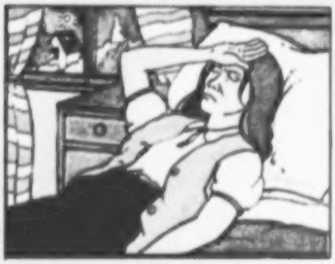
---

bloedend tandvlees	*diesj è-tie-mie kà-nù-jòr?*	**diş etimi kanıyor?**
voor controle	*kon-trol ie-tsjien*	**kontrol için**
naar de tandarts gaan	*diesj dok-to-roe-na gie-dien*	**diş doktoruna gidin**



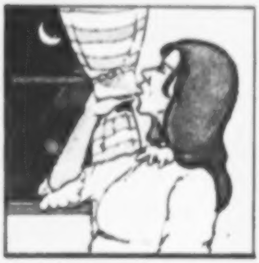
BAŞ AĞRISI VE YORGUNLUK

Hoofdpijn en moe.



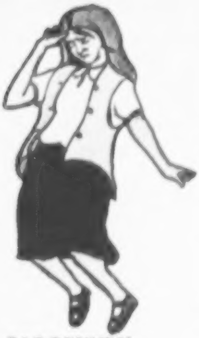
Öğleden sonra biraz yatağa uzanınız.

Ga 's middags even op bed liggen.



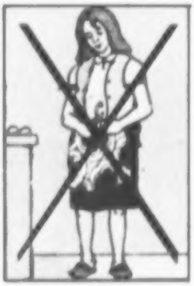
Akşamları, yatmadan önce bir bardak sıcak süt içiniz.
Akşamları, erken yatınız.

Drink een glas warme melk voor u 's avonds naar bed gaat.
Ga 's avonds vroeg naar bed.



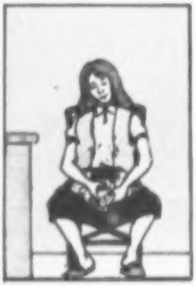
BAŞ DÖNMESİ VE BAYILMA

Duizelig en flauwvallen.



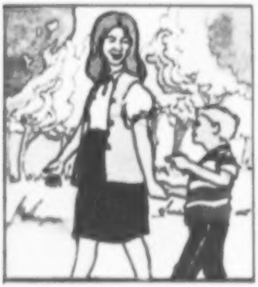
Ayakta fazla durmayınız.

Lange tijd staan is niet goed.



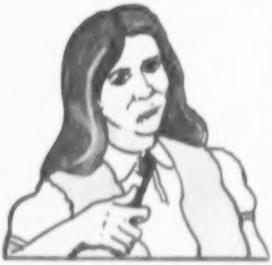
Mümkün olduğu kadar, oturunuz.

Zitten is goed.



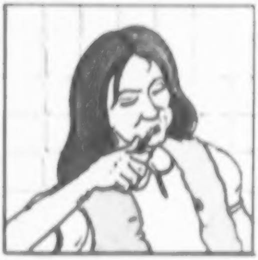
Yeteri kadar temiz hava almaya çalışınız.

Frisse lucht is goed.



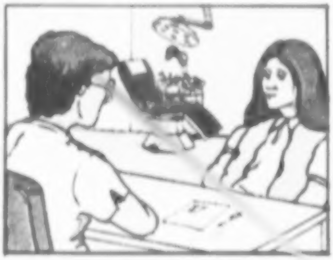
DİŞ ETLERİNİN KANAMASI

Tanden poetsen en bloed.



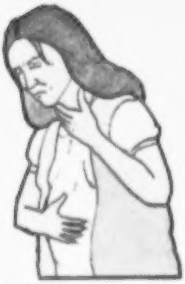
Dişlerinizi ve diş etlerinizi fırçalamaya devam ediniz.

Niet ophouden met het poetsen van tanden en tandvlees.



Kontrol için, diş doktorunuza gidiniz.

Ga naar de tandarts voor controle.

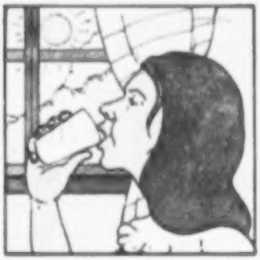


MİDE YANMASI

Maagzuur.

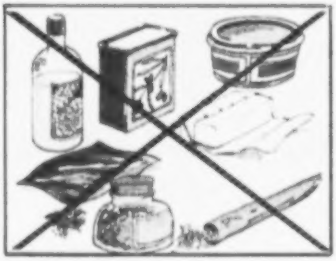
Gebeliğin son aylarında, bu çok olur.

Dit is normaal in de laatste maanden van de zwangerschap.



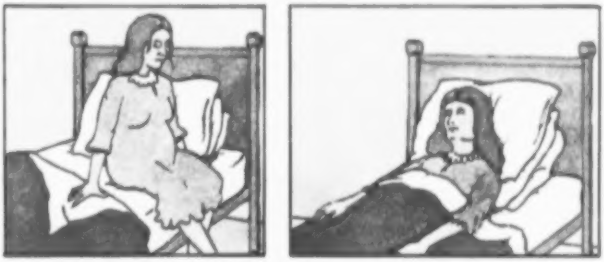
Bir bardak sıcak süt içiniz.

Drink een glas warme melk.



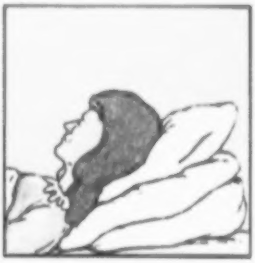
Baharatlı ve yağlı yemekler yemeyiniz.

Eet geen kruiden en vette gerechten.



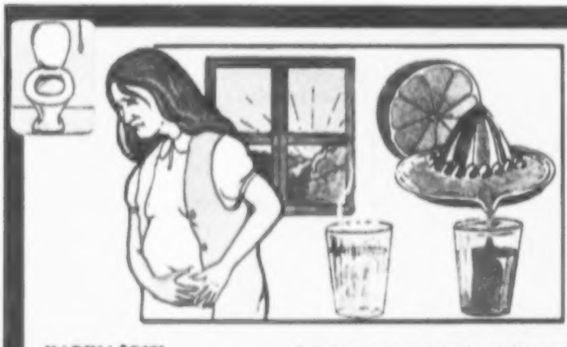
Uyumak istiyorsanız, birdenbire yatağa uzanmayınız. Önce oturunuz ve sonra yavaşça yatınız.

Als u naar bed gaat: ga eerst zitten en daarna langzaam liggen.



Başaltına ek bir yastık koymakta fayda vardır.

Een extra kussen is goed.

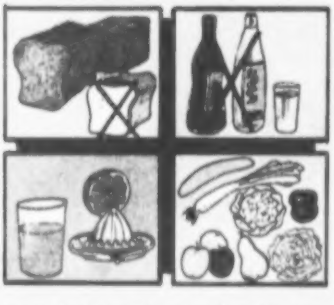


KARINAĞRISI VE KABIZLIK

Buikpijn en problemen bij het poepen.

Sabah erken zamanlarda, aç karnına bir bardak sıcak su ya da sıkılmış portakal suyu içiniz.

Drink vóór het ontbijt een glas warm water of sinaasappelsap.



Beyaz ekmek yerine, esmer ekmek ve çavdar ekmeği yiyiniz. Bolca taze sebze, kuru sebze ve meyva yiyiniz. Taze meyva suyu içiniz. İçinde asit olan meşrubat içmeyiniz.

Eet bruin brood of roggebrood. Eet geen wittebrood. Eet veel verse groenten, peulvruchten en fruit. Drink vers vruchtesap. Drink geen drank met prik.

Met deze woordjes kunt u de boodschap op blz. 3 uitleggen

nederlands	turkse uitspraak	turks
maagzuur?	*mie-dè-niez-mie jà-nù-jòr?*	midenizmi yanıyor?
beetje	*bie-ràz*	biraz
melk	*suut*	süt
drinken	*ie-tsjien*	için
vet eten	*jàh-lù jè-mèk*	yağlı yemek
kruiden	*bè-hà-ràt*	baharat
niet goed	*ie-jie dè-iel/jòk*	iyi değil/yok

---

vòòr het slapen	*oe-joe-mà-dàn*	uyumadan
eerst	*eun-dzjè*	önce
zitten	*ò-toe-roen*	oturun
daarna	*son-rà*	sonra
langzaam	*jà-wasj-tsjà*	yavaşça
liggen	*oe-zà-nùn*	uzanın
extra	*ekstra*	ekstra
hoofdkussen	*jàs-tùk*	yastık
goed	*ie-jie*	iyi

---

buikpijn?	*kà-rùn àh-rù-sù?*	karın ağrısı?
harde ontlasting?	*kà-bùz-lùk-mù wàr?*	kabızlıkmı var?
's morgens	*sà-bàh-là-rù*	sabahları
niet eten	*jè-mèk jòk*	yemek yok
eerst	*eun-dzjè*	önce
warm water	*sù-dzjàk soe*	sıcak su
sinasappelsap	*por-tà-kal soe-joe*	portakal suyu
uitpersen	*sù-kùp*	sıkıp
drinken	*ie-tsjien*	için
daarna	*sòn-rà*	sonra
bruinbrood/ roggebrood	*tsjàw-dàr èk-mè-ie*	çavdar ekmeği
verse groenten	*tà-zè sèb-zè*	taze sebze
peulvrucht	*koe-roe sèb-zè*	kuru sebze
fruit	*mèj-wà*	meyva
eten	*jie-jien*	yiyin
vers vruchtesap	*tà-ze mèj-wà soe-joe*	taze meyva suyu
drinken	*ie-tsjien*	için
witbrood	*bè-jàz èk-mèk*	beyaz ekmek
niet goed	*ie-jie dè-iel/jòk*	iyi değil/yok
drank met prik	*ga-zeuz*	gazöz
niet goed	*ie-jie dè-iel/jòk*	iyi değil/yok

Met deze woordjes kunt u de boodschap op blz. 4 uitleggen

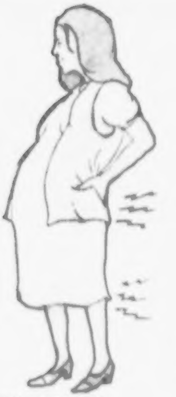
nederlands	turkse uitspraak	turks
spierpijn?	*à-dè-lè àh-rù-sù?*	**adele ağrısı?**
buikpijn?	*kà-rùn àh-rù-sù?*	**karın ağrısı?**
rugpijn?	*bèl ah-rù-sù?*	**bel ağrısı?**
kuitpijn?	*bà-dzjàk ah-rù-sù-mù wàr?*	**bacak ağrısımı var?**
normaal	*nor-mal*	**normal**
met hoge hakken	*juuk-sèk tò-poek-loe*	**yüksek topuklu**
schoenen	*àj-jà-kà-bù*	**ayyakabı**
niet goed	*ie-jie dè-iel/jòk*	**iyi değil/yok**
lage schoenen	*àl-tsjàk àj-jà-kà-bù*	**alçak ayyakabı**
goed	*ie-jie*	**iyi**
zwaar tillen	*à-ùr kàl-dùr-màk*	**ağır kaldırmak**
niet goed	*ie-jie dè-iel/jòk*	**iyi değil/yok**
bij het optillen	*kàl-dùr-màk ie-tsjien*	**kaldırmak için**
door de knieen buigen	*tsjeuk-mèk*	**çökmek**
goed	*ie-jie*	**iyi**

---

van onderen	*à-sjà-ù-dàn*	**aşağıdan**
veel	*tsjòk*	**çok**
afscheiding?	*à-kùn-tù-mù wàr?*	**akıntımı var?**
met water	*soe ie-lè*	**su ile**
wassen	*jù-kà-jùn*	**yıkayın**
geen zeep	*sa-boen jòk*	**sabun yok**
vaak	*sùk sùk*	**sık sık**
wassen	*jù-kà-màk*	**yıkamak**
niet goed	*ie-jie dè-iel/jòk*	**iyi değil/yok**

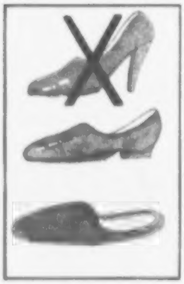
---

van onderen	*à-sjà-ù-dà*	**aşağıda**
jeuk?	*kà-sjùn-tù*	**kaşıntı**
branderig gevoel?	*jàn-mà-mù wàr?*	**yanmamı var?**
voor controle	*kon-trol ie-tsjien*	**kontrol için?**
naar dokter gaan	*dok-to-ra gie-dien*	**doktora gidin**
of	*jà dà*	**ya da**
naar verloskundige gaan	*è-bè-jè gie-dien*	**ebeye gidin**
van onderen	*à-sjà-ù-dàn*	**aşağıdan**
bloed?	*kàn-mù gè-lie-jòr?*	**kanmı geliyor?**
naar verloskundige gaan	*è-bè-jè gie-dien*	**ebeye gidin**
of	*jà da*	**ya da**
opbellen	*telefon è-dien*	**telefon edin**



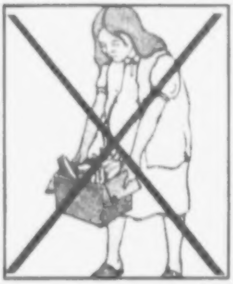
KARIN, BEL VE BACAK ADALESİ AĞRILARI

Spierpijn in buik, rug en kuiten.



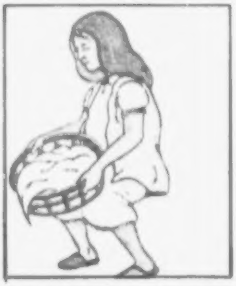
Rahat ayakkabılar giyiniz. Yüksek topuklu ayakkabı giymeyiniz.

Schoenen met lage hakken zijn goed.
Schoenen met hoge hakken zijn niet goed.



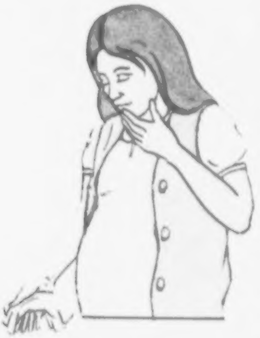
Ağır şeyler kaldırmayınız.

Til geen zware dingen.



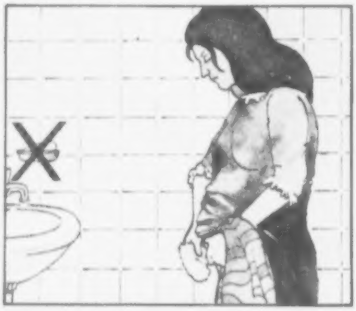
Bir şey kaldırırken diz üstü çökünüz.

Als u iets optilt,
zak dan door de knieën.



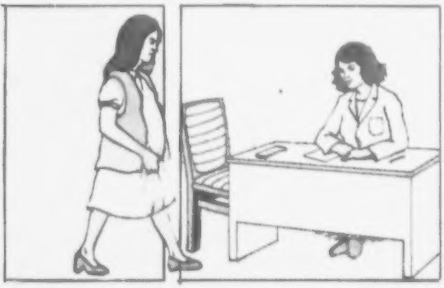
Hazneden, çok fazla akıntı.

Veel afscheiding uit de vagina.



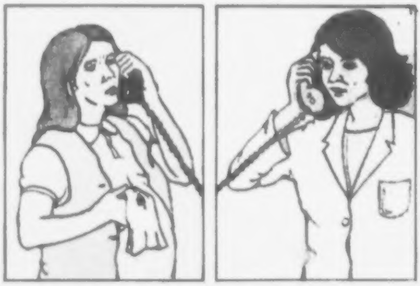
Vücudunuzun altını su ile yıkayınız. Sabun kullanm.. yıkayınız. Çok sık ve sert yıkanma, şikâyeti sadece faz.

Was het onderlichaam met water. Gebruik geen zeep.
Was voorzichtig. Veel en hard wassen maakt de klachten erger.



Kaşıntı ya da yanma hissedilirse, ebe ya da ev doktoruna gidiniz.

Als u van onderen jeuk hebt,
moet u naar de verloskundige of huisarts gaan.



Akıntı kanlı ise, ebeye telefon etmelisiniz.

Als er bloed in de afscheiding is, moet u de verloskundige bellen.

CHAPTER XI MENTAL HEALTH OF MIGRANTS

M.P. Simoes

METHODOLOGICAL RESEARCH PROBLEMS

Introduction

The mass immigration of foreign workers to the industrialised regions of central Europe, mainly coming from the Mediterranean area, involves important social adaptation processes for both the immigrants and the receiving countries. These social problems have stimulated a great number of research projects on migrants and their adaptation problems. The impact of migration on mental health has traditionally been an important topic in social psychiatry. However, the term migration is used to refer to rather different social phenomena: migration from rural to urban areas, inter-continental migration, forced migration as a consequence of political repression and wars as well as the more recent forms of temporary economic migration in Europe. The latter type of migration is specific in so far as the working migrants to central Europe see their migration only as temporary and therefore do not try to become integrated in the host country, even if in fact the temporary stay becomes a permanent one. There is a lack of pertinent research on the mental health situation of these immigrant workers.

Summarised Review of the Literature

A review of the literature about mental illness in migrant workers by Binder and Simoes (1978) can be summarised as follows. There are contradictory findings on the question whether the incidence and prevalence of mental disturbances in migrant workers are higher or lower than in other groups. These inconsistencies come mainly from methodical reasons, that shall be discussed in the next section. It therefore cannot be taken for granted that migrants suffer more often from psychiatric disturbances than either the population of their homeland or that of the country of immigration. There is agreement that differences between the migrant's culture and that of the country of immigration (language, mythical beliefs, illness behaviour) shape the manifestation of psychiatric syndromes. The following syndromes are considered to be typical for migrant workers: paranoid reactions, hypochondriac-depressive syndromes, psycho-somatic conditions and sexual neuroses. There seem to be two high-risk periods for migrants: one shortly after the immigration and another after a period of several years in the host country. There is also empirical evidence for different sociological explanations of mental illness in migrant workers: selection theory (assuming that persons who decide to emigrate do so because of their poor mental health) vs. social causation theory (the latter including effects of low socio-economic status, isolation, goal-striving stress, culture-shock and cultural change on mental health).

Methodological Problems and Requirements

The literature about mental health of migrant workers consists primarily of two types of studies about the mental health of immigrants: casuistic studies and statistical analyses of the admission rates of psychiatric hospitals. Most of these studies suffer from severe methodological shortcomings in so far as they concentrate on treated mental illness and lack adequate control groups.

The old socio-psychiatric studies concerning mental health, in the United States, showed that immigrants suffered a high psychiatric morbidity. It was then thought that as well as in Europe, immigrants suffer more from psychiatric diseases than those staying in the homeland. This transfer of the American experiences to the circumstances of the European immigrants assumes, that both groups are confronted with similar socio-structural and cultural conditions. Although this similarity can be accepted altogether, there are some important differences among the European immigrants, that one must point out. Many of them consider their sojourn in a foreign country only as temporary. This is conditioned by unemployment in the homeland or by the wish to obtain a social ascent ("goal-striving") through a temporary stay abroad. As a consequence of it, many of them actually immigrate without an integration perspective in the recepient country.

On the other side, the foreign policy of most European countries, does not support integration of the foreign workers. Instead it makes it difficult for them, even after some years sojourn (restrictions on work and family joining).

Control Groups

Two control groups are conceivable as a basis for evaluating the incidence and prevalence of mental disturbances in migrant workers: the population of the host country and that of the homeland. Though most studies with control groups compare migrants with the population of the host country, this approach is not suitable for demonstrating the stressful effects of migration; there might also be an initial difference in prevalences of mental disturbances in the home and in the host country. Since emigrating persons are typical of the parent population in respect of criteria such as age, sex, social status and urban/rural origin, control groups have to be carefully matched or the differences corrected by statistical techniques.

Social Aspects

Studies based only on hospital statistics should be considered with reservation concerning conclusions about the true incidence and prevalence of psychiatric disorders in foreign workers. A number of intervening variables influence the measured differences between immigrants and the native population: different behaviour regarding illness as well selective procedures of admittance to a hospital and treatment, which are particularly stressed through language difficulties. Altogether one cannot evaluate, if these intervening variables lead to an over- or under-representation of immigrants in the statistics of health services utilisation.

Pathology

The different studies on this subject show that immigrants differ from the host population, rather in the way they present their complaints (pathoplastic), than in the total morbidity rate. This means that comparisons should be made according to specific pathology (psychosis, neurosis and psycho-somatic disorders). Specially in relation to the socially not so visible psychic disorders (neuroses and psycho-somatic disorders), the statistics mentioned above, give an unsatisfactory view that must be completed through field studies.

Field Studies

These studies, when carried out in a randomised population, are suited for evaluating the incidence and prevalence of disorders. The randomisation doesn't exclude any member of the studied population, ill or not.

One must take into account, that these studies are more difficult to perform than those made in "laboratory". In the United States and a great part of Europe, the relation between investigator and experimental subject is impersonal and clearly defined. The objectives of the investigator are well known. This is not generally the case among immigrants. One must accept an initial mistrust and try to gain their motivation for the study. The importance and meaning of these studies are not generally understood by them. These are rather felt as a strain and when discussing intimate problems shyness and resistance appeared.

The scientist should preferably be introduced by someone representative and respected in the community, stressing that answers are confidential and have nothing to do with "political motivations" from the points of view of both host and home countries, but only with "health problems". Immigrants are generally afraid of political or police issues.

A first contact should be made after the introduction, only for talking, participating in their social life and making an appointment for a later interview. Some attention on the "somatic" side, e.g. taking the blood pressure, makes the last distrust vanish. For more information on these aspects read Figueiredo (1976). Last but not least, the investigators should speak the same language as the studied group.

Longitudinal Studies

As a consequence of the above-mentioned considerations, the ideal design should be a longitudinal study.

For this purpose the immigrant group should be studied in the home-country before immigration or on arrival and then followed at different intervals, as it was done in the study of Haefner et al. (1977).

A SOCIAL-PSYCHIATRIC FIELD STUDY

The following points are mainly based on already published works (Simoes, 1978; Binder and Simoes, 1978; Binder and Simoes, 1980; Simoes, 1980; Simoes and Binder, 1980; Simoes, 1983).

Some Data

A sample of one hundred Portuguese migrant workers in the canton of Zurich, Switzerland, was interviewed in an epidemiological field study with a standardised psychiatric questionnaire (SCL-90-R), from Derogatis (1977) and compared with two control groups: Portuguese workers in Lisbon and a Swiss sample. Both control groups were matched to the target group.

All interviews were conducted by the author in the Portuguese language. Because of a careful introduction of the project and the interviewer, the refusal rate remained very low (5%).

No member of the sample was receiving psychiatric treatment.

Research Questions

The research questions were as follows:

1. Are emigrating individuals characterised by either a disturbed personality or by positive mental health?
2. Are there any differences in mental health between emigrants and the population of the home country?
3. Are there any differences in mental health between the emigrants and the population of the host country?
4. Which types of disturbance or "psychological traits" are most frequent among migrants?
5. Are there any factors in the culture and social structure of the immigration country that affect the migrants' mental health?

Results

Referring to Question 1:

Table 1: Mental Health (last five years)

Mental health (Use of psychotropic drugs)	Migrant workers (n = 100)	Control group Lisbon (n = 49)
Men	15%	39%
Women	28%	43% n.s.

Only 5% of them had consulted a psychiatrist in a 5 year period before their immigration.

Referring to Questions 2, 3, 4:

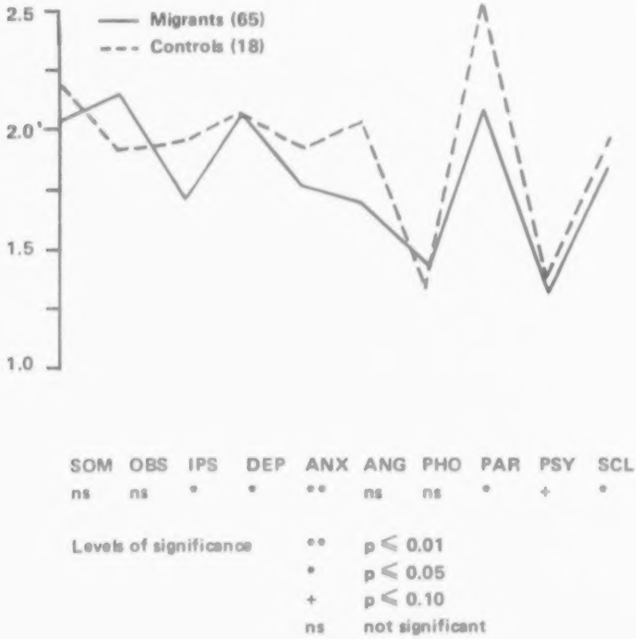


Figure 1: Male migrant workers vs. control group males in Lisbon

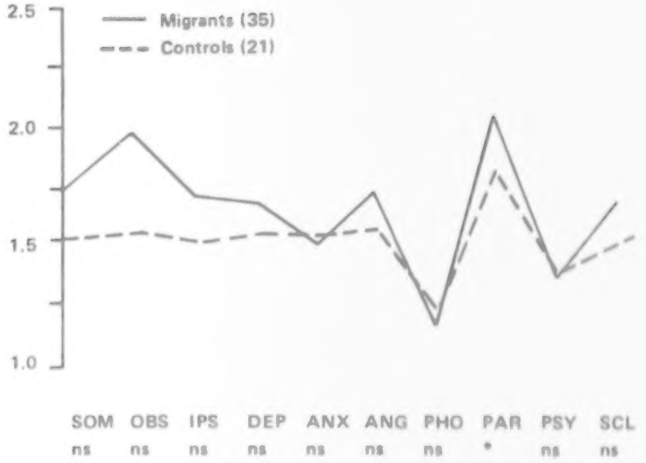


Figure 2: Female migrant workers vs. control group females in Lisbon

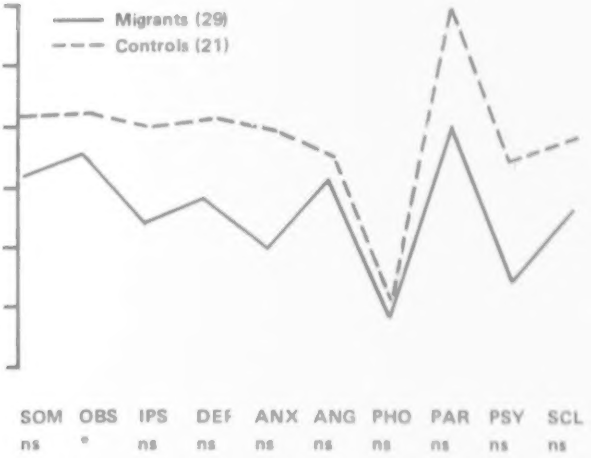


Figure 3: Young male migrant workers vs. control group young Swiss males

Referring to Question 5

Differences concerning sub-groups such as under-privilege, culture shock, cultural change and "goal-striving stress" were not statistically significant.

Conclusions

1. Migrant workers do not have a characteristic premorbid personality in the sense that they are persons with psychological problems prior to their emigration. Rather they seem to be psychologically resistant.

2. The mental health of Portuguese migrants to Switzerland is significantly better than that of non-mobile workers in Lisbon.

3. As far as the Swiss control group is comparable, the emigrants showed no significant differences in comparison to the host population, except on one scale (obsessional-compulsive traits).

4. Since none of the investigated sample suffered from psychiatric illness, it was not possible to detect clinical syndromes typical for migrant workers. We detected as a characteristic psychological trait of migrants only higher values for obsessionality.

5. Our data does not confirm any current socio-psychiatric hypotheses about causation of mental disturbances in migrants.

Before concluding, we would like to point to some limitations of our approach:

1. All persons in our sample were within the bounds ofclinical normality. They differed only with respect to their score on a standardised psychiatric questionnaire. Generalisations about severe mental disturbances may not be accurate.

2. It may be, that these results cannot be generalised to migrant workers from countries other than Portugal. Portuguese migrants in Switzerland are more satisfied with their working condition than workers in Portugal. Although the migrant worker lives in a situation with much discrimination, this is outweighed by the fact of relative social stability and material security in the host country.

SUGGESTIONS FOR HEALTH CARE

After a long contact with the migrant population we could see and hear about needs that in some cases were pointed out by the immigrants.

Sociological

1. Reformation of the consulate services and adaptation of their services to the needs of immigrants:

    - information activities
    - cultural and social promotion
    - defence of rights
    - simplifying bureaucracy
    - opening hours adapted to immigrants.

2. Minimal information on the host country, before departure or on arrival, specially concerning employment conditions, habitation, education of children and social ambience. They should be taught a minimal vocabulary and taught how to handle a simple dictionary.

3. Radio and T.V. programmes for immigrants in their language concerning political, social, economic and cultural aspects of both home and host countries.

4. Possibility of political participation of the immigrant in the host country, at least at a local level.

5. Creation of meeting centres in the host country or support to those already existing (cultural and informative, theatre and cinema).

6. Planning return: creating jobs with money sent by immigrants; use of their technical capacity acquired abroad; stimulating the foundation of factories partly financed by immigrants.

7. End of the status of temporary worker or at least, give them the chance of reuniting their family.

On Health

1. Physicians should speak the same language, or even better, be compatriots. Because of some professional regulations in each country, these compatriot doctors may well be only authorised to work as advisers to other doctors or institutions dealing only with immigrants, having a prefixed salary or not.

2. Weekly or monthly visits of compatriot doctors to migrant communities.

3. Posters, films and meetings in the migrants' own language advertising for prophylaxis and health care in the working places or communities.

4. Preparation of teachers and priests on some somatic and psychological aspects of health and how to deal with them.

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CHAPTER XII: PSYCHO-SOCIAL PROBLEMS OF MIGRANTS

W. Alma

General discussion on psycho-social problems in migrants[*]

The first point to raise is that instead of me discussing or writing about the psycho-social problems of migrants, a direct representative of the group we are talking about should have been present. He or she certainly could have given a better account of the needs of migrant workers.

If after all I have accepted, it is because, being in the very privileged situation of living and working with migrant families of seven nationalities, I may be able to interpret their anxieties. Moreover, I feel that discussion on this subject is still urgent, even more urgent than ever before.

When I say still urgent, it is because already from the first years of "guestworkership" in western and northern Europe, much has been written and many discussions have been held on the mental health of migrants on a national as well as on an international scale. Unfortunately the migrants themselves were missing here too often.

Mental disorders, psycho-social problems and their possible origin, there, where the actual migrants are concerned, have been mentioned in publications as early as 1947, shortly after the Second World War, and probably even before.

[*] Based on a discussion initiated by Mrs. Alma at the World Health Organization meeting, The Hague, November, 1983.

And at the same time in that early stage, signals were already sent out on the problematic situation that might arrive in the years to come.

Today, in 1983, there are about 14,000,000 migrants in Europe and about 30 years of intensive foreign labour activities have passed.

Can we say that many problems have been resolved? On the contrary - they are still there and we have to admit that the situation has grown worse.

Let us review briefly:

> As we all know, not only men, but also women and children belong to the migrant population.
>
> A Dutch psychiatrist*, who works with clients from ethnic minority groups and much with Moroccans, conversant with the Arabic language, gives four lists with possible problems, that is: psycho-social problems for migrant men, for migrant women, for migrant boys and for migrant girls.

The sub-division is as follows:

Psycho-social problems for migrant men:

Working conditions: Work in relays, overwork, menace of dismissal, unemployment, discrim-ination, lack of prospects and family problems.

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* Mrs. A. Limburg-Okken

Housing Conditions:	Living in hotels, in slums, in ghetto areas, in overcrowded houses, sleeping many times during daytime in noisy rooms.
Financial Conditions:	Obligations towards relatives in home country.
	Obligations during holidays.
	Furnishing of the house at the arrival of the family.
	Debts in paying rent or mortgage.
	Problems with many kinds of grants and benefits.
"Paper" Insecurity	Permit to stay, working permit, permit for holidays.
	Fear of "forced" re-migration.
	Fear of having social benefits stopped.
Sexuality Problems	Impotence, masturbation problems, fear and shame of venereal diseases.

Psycho-social problems for migrant women:

Problems, rising from working, housing, financial and "paper" conditions may concern migrant women as much as the men.

Special problems are:

Sexuality Problems	Questions about contraception, infertility.
Ill-treatment	With regard to relation problems. Fear of repudiation (According to Dutch law, a migrant woman has to stay for three years with her husband, before being able to obtain divorce and with that a personal permit to stay.).
Social Isolation	Lack of contact with other women (relatives, or those from same village, region or country.) Homesickness. Language and culture barrier between her and her children. Incapacity of communi-cation, for instance while shopping, in talking with neighbours, etc.

Psycho-social problems for migrant boys:

Authority Conflicts	Problems with regard to the father, such as: leisure time, religious duties, use of tobacco, drugs or alcohol, choice of boy and girl friends.
School and Work Conflicts	Age of compulsory education.
	Schools insufficiently adapted to foreign pupils.
	Absenteeism.
	Desire to reach a high education level, reality of not getting to it.
	Desire for work, reality of unemployment.
	Fear of forced re-migration.
"Runaway" Behaviour	In certain countries is more accepted, the fact remains inside the family circle, as where, for instance, in Holland official organisations may help the young people and interfere with parents.

"Petty Criminality" Behaviour	Boys may steal small things as toys or sweets in order to win respect or friend-ship of schoolmates.
Sexuality Problems	Lack of information of European way of giving sex information. Early marriage arrangements by parents. Girlfriends of other nationality. Official impediments to get married with girl from home country because of work, salary or age restrictions.

Psycho-social problems for migrant girls:

Authority Conflicts	With regard to father and mother, concerning use of make-up, cutting off long hair, adopting modern behaviour, leisure time and activities outdoors. Overburdening because of household and school tasks, especially when being the eldest daughter or in case of illness of mother.

School Problems	Prohibition of excursions, mixed classes, swimming lessons, "no need for girls to go to school", compulsory education age.
Sexuality Problems	Fear of loss of virginity, fear of getting married early and to an unknown man.
"Runaway" Behaviour	Judged as a shame for the whole family. Again, official organisations will help the girls.

I think, this picture cannot be new to of us. So, summarising, we may say that a migrant's life is characterised by a high vulnerability, as the result of:

- the language barrier
- the culture barrier
- the so-called "condition migrante" or "migrant condition".

Important **features of this "migrant condition"** include:

- the permanent temporality
- the heavy social control within the migrants' own group
- the fact of being a displaced person, as much in the host-country as in the country of origin

- the lack of up-to-date information
- the social disadvantage
- problems between the first and second generation
- prejudices to and from people in the host country
- heavy financial obligations.

It is clear that these conditions must lead towards an increase of the burden to which the migrant is exposed, mentally and physically.

It means that migration is causing stress, which may lead to losing important parts of health.

Now, how can we, contribute to a decrease of the problems mentioned above and to an improvement of the migrant's life?

The definition of health of the World Health Organization is:

> **HEALTH IS A STATE OF COMPLETE PHYSICAL, MENTAL AND SOCIAL WELL-BEING, AND DOES NOT CONSIST MERELY THE ABSENCE OF DISEASE OR INFIRMITY.**

These words should be the starting point for a general discussion.

Can we look together at the different possibilities of help?

Should priority be given to:

- the increase of highly specialised medical or psychological personnel?
- the support of the ethnic groups themselves, so that they may take their own responsibilities and utilise to the utmost their many capacities?
- the preventive help, given by family doctors - G.P.'s, health care fieldworkers or social workers?
- actions in the social field, such as, for instance, combatting discrimination and discriminatory laws and conditions?
- housing, leisure and school conditions.

Also these points may serve the general discussion.

I'd like to finish this introduction with a question of an old African village woman, quoted by Fuglesang in his book About Understanding:

> **"Why do you, white person, not try to understand the minds of Africans more than their ability to work? You people do not understand your words do not belong to our minds."**

PART V

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS AND RECOMMENDATIONS

M. Colledge and
P-G. Svensson

The chapters in this book have addressed a wide range of issues related to the health of migrants in Europe, and also given a wide range of perspectives from social scientists, doctors and other health care workers. From these contributions we will attempt to draw conclusions and recommendations which can be translated into plans of action for researchers, and practitioners alike.*

Research policy with particular reference to ethnic groups

It has been demonstrated quite clearly by a number of authors that there is a need to improve the data base for migrant groups, most of the evidence is fragmentary and cannot readily be adapted to policy. Access to health data can be difficult, and there is a need to improve the methods used to collect vital statistics so that comparisons can be drawn within countries. To facilitate better health and social services, target groups need to be identified by a mix of qualitative and quantitative methods which can outline service and personal needs at a national and regional level. In-depth studies and small area analysis could be used to identify characteristics and needs of ethnic populations. Evaluation research should be used to test the effectiveness of health education programmes and general health information provided by

* The recommendations and conclusions are based on the outcome of the World Health Organization meeting of experts in The Hague 1983, and agreed unanimously as a guide for further action at an international, national and local level.

the host country for migrants. When setting up a data base researchers and institutions should be sensitive to the privacy of minorities and be alerted to the possible misuse of information.

Health care delivery policy

All provisions for ethnic minorities in host countries should be integrated into the existing health care programmes provided for the indigenious population. Special needs can be met by encouraging domiciliary visits, improving facilities for information and education. To this end full use should be made of interpreters, bilingual and bicultural health workers and the migrants' news media. Meetings with migrant groups allow needs as perceived by the minority to emerge avoiding the dangers of medicalisation of the migrants problems of adjustment. Traditional resources should be fully utilised and alternatives to western medicine taken into account and recognised. In general, health planners should take into account the demographic characteristics of ethnic groups within the host population when allocating resources, paying particular attention to density, age and sex distribution. Specifically the needs of elderly and women migrants should be taken into account.

International aspects of migrant health care

To achieve better health care for migrants in the host country, cooperation between host country and country of origin is essential at a governmental and non-governmental level. Exchange of health education programmes and information will overcome language difficulties and cultural barriers. It is recognized that some migrants when elderly will return to their country of origin. Their health and welfare can only be protected if both countries take this into account when planning health policy.

It has been discovered that some elderly migrants have in the past had the date of birth changed in their passports so that they appeared younger and eligible for immigration. Now they have reached the age of sixty-five and cannot claim retirement benefits. The only way this dilemma can be overcome is by collaboration between nation of origin and host country.

Illegal immigrants pose special health problems for both host country and country of origin by the fact that they are open to exploitation in the work setting. The nature of their illegal status may lead to illness which is difficult for the host country to trace and prevent, also the country of origin may for the same reason find workers returning ill. An international perspective and increased cooperation can combat the dangers of racism and also allow a more critical awareness in the host country that what are seen as migrant problems could be problems of the society generally.

RECOMMENDATIONS

1. World Health Organization and national governments should support more coordinated in-depth studies of migrants' health with special reference to mortality and morbidity by country of orgin.

2. World Health Organization should promote the exchange of programmes and information between countries through their periodicals or any other means, and by meetings and symposia so that researchers can discuss their findings across cultural borders.

3. It is recommended that the World Health Organization programmes on the health of the elderly, and the prevention and control of alcohol and drug abuse give special attention to ethnic minorities.

4. Illegal immigrants should be recognized as having special problems and migrants' health status should be given priority.

5. Folk medicine, when it can be a useful way of reaching migrant groups, should be given proper recognition.

6. Training programmes and curricula for health personnel should include information on the health of ethnic minorities. It is recommended that bicultural experience and bilingualism be given additional merit within the health and social services.

7. In host countries of origin, it is recommended that focal points for migrants be appointed across ministerial and authority boundaries, at the national, country/area and local levels.

ANNEX 1

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Unequal distribution of health care is an important issue for WHO in the European Region. The organization of health services for the so-called "vulnerable groups" in society imposes a particular challenge for primary health care. Not the least vulnerable are migrant workers and their families, now numbering over 15 million in western Europe alone.

This book, based on the proceedings of a consultative group organized jointly by WHO and the Government of the Netherlands, highlights the urgent need to tackle the problem of health care for ethnic minorities. It reveals the inadequacy of current research and data collection methods to support the formulation of relevant health policies. There is a need for an understanding of migrants' perceptions of their own health, concentrating on cultural and language barriers rather than "race" as such. The inability of the health services in the host country to adapt to the needs of migrants is reflected in research being directed towards certain conditions that appear to affect particular ethnic groups, such as rickets or sickle cell anaemia, or to topics of special research interest to the medical practitioner. At best, such research is insensitive and shows a failure to understand non-European cultures and their way of life; at worst it deprives migrants of even the basic elements of health and social welfare.

The picture is not altogether bleak. In several host countries moves are being made to introduce health concepts to immigrant families, through printed and audiovisual materials, counselling services and other means. But the debate needs to be carried to a wider audience of researchers, health workers and educationalists if real progress is to be made in bringing adequate and acceptable health care to these people. That is what this book sets out to do.